The Right to Choose

Enhancing best practice
in responding to
sexual assault in Queensland

Author (for citation): *Queensland sexual assault services*

Written & Compiled by: Suzi Quixley, ESSQ Community Services Consultancy, Bowden, South Australia.
Cover design by: Thi Thanh Tam Pham 2010

Contents

Executive Summary

This report proposes an evidence-based, holistic response to sexual assault in Queensland. It advocates a system designed to enable Queensland to move toward the reduction, and ultimate elimination, of sexual violence. This requires viewing sexual assault as primarily a social, rather than an individual or medical, problem.

The need for this report was originally driven by release of a review of Queensland Health responses to adult victims of sexual assault conducted by KPMG in 2008 (http://www.health.qld.gov.au/sexualassault/docs/KPMGreview.pdf), which proposed a single model of service for the sexual assault service delivery sector in Queensland. All 20 non-government sexual assault services in Queensland have contributed toward this report, which proposes an alternative service delivery system, designed to better address the diverse needs of the Queensland community.

Sexual violence is a major social and economic problem. The data indicates that over 125,000 incidents of sexual assault are likely to be perpetrated against women in Queensland each year, (see p.9). A significant majority of these women will not report the incident. Further, about half these women will experience symptoms later in life with serious potential consequences for themselves, their children and the wider community. At least one quarter of the women in Queensland can be expected to experience sexual violence during their lifetime. Nationally, unless this epidemic is addressed, the economic cost of violence against women (including sexual violence) is expected to reach $15.6 billion by 2021-2022, (see p.15).

Sexual violence is overwhelmingly perpetrated by men, against women. Reducing rates of sexual assault requires a human rights driven approach, based on a gendered analysis of sexual violence. It is nationally and internationally recognised that best practice in community education, prevention and early intervention is driven by a gendered analysis of sexual violence. Recognised best practice in direct service delivery acknowledges the importance of a gendered analysis of sexual violence in intervention with both recent and past victims/survivors of sexual assault. Recognised best practice treats prevention of violence and intervention as interdependent. Community-based sexual assault services have developed models of service customised to the needs of their particular communities, which integrate prevention and intervention. These services have taken the lead role in provision of community education in Queensland.

Collectively, government and non-government sexual assault services across Queensland contribute to providing the most complete and accessible service possible within existing limited resources. These include medical, legal and psycho-social services. However, current resources fall far short of current and projected future demand for services. This report proposes a significant increase in funding to the sexual assault service delivery sector, proportional to the size and impact of this social and economic problem.

An equitable response to sexual violence demands a focus on meeting the needs of women who have been sexually assaulted, particularly groups of women at higher risk of sexual assault. Indigenous women, immigrant and refugee women, young women, women with disabilities, criminalised women and women from rural and remote areas, experience high rates of sexual violence. Non-government services have developed models of service customised to the particular needs of women in their various target communities.

Queensland sexual assault services support best practice and continuous quality improvement in responding to the needs of victims/survivors of sexual assault. A wealth of accumulated expertise currently exists across the Queensland sexual assault sector. This report proposes that the most cost effective means to address sexual violence is to build on the existing strengths and skills of the sector. This requires maintenance and further development of the current collaborative relationships between service providers, and improved professional development opportunities.

This crisis demands a dedicated, whole of government, community-informed, state plan to reduce sexual violence, and meet the needs of people who have experienced sexual assault, throughout Queensland.

List of Recommendations

Recommendation 1: That the Queensland Government adopt a comprehensive response to sexual violence involving collaboration with victims/survivors, sexual assault services, health workers, police and the criminal justice system in order to develop safe, meaningful and effective programs for a diverse range of victims/survivors (particularly relevant to rural and remote areas).

Recommendation 2: That the Queensland Government recognise that the structural, economic and cultural values of our society give power to men, making women more likely to be victims of sexual assault.

Recommendation 3: That the Queensland Government recognise the gendered nature of sexual violence and advocate and support a gendered analysis as a best practice approach to both intervention and prevention work.

Recommendation 4: That the Queensland Government acknowledge the inherent importance of *women's only space* to providing a safe and supportive environment to meet the physical, emotional and psychological safety needs of women who have experienced sexual assault.

Recommendation 5: That the Queensland Government analyse the social and economic cost of focussing on crisis services and identify opportunities to invest in prevention and early intervention.

Recommendation 6: That the Queensland Government enhance funding and resources to existing programs that are currently working well before embarking on any new untested responses.

Recommendation 7: That the Queensland Government formally recognise the importance of networking and interagency collaboration and the central role these play in providing efficient, effective and holistic service delivery (particularly relevant to rural and remote areas).

Recommendation 8: That the Queensland Government provide increased funding to the Statewide Sexual Assault Helpline to:

- Enable provision of a 24 hour service.
- Enable comprehensive marketing of the service to maximise community access.

Recommendation 9: That the Queensland Government continue to engage both government and non-government service providers in order to address the diverse needs of people who have been sexually assaulted, recently or in the past.

Recommendation 10: That the Queensland Government commit to provision of crisis support services for victims of sexual assault, which meet recognised national best practice criteria and the overarching principles of the Queensland Health Interagency Guidelines.

Recommendation 11: That the Queensland Government ensure that, consistent with the Interagency Guidelines, victims of sexual assault are given the choice to have immediate forensic collection with delayed release to the police.

Recommendation 12: That the Queensland Government continue to support and resource sexual assault services to provide flexible, holistic, ongoing counselling to survivors of childhood and past adult sexual assault.

Recommendation 13: That the Queensland Government make additional funding available to develop safe, ethical, professional services for men and young men who have been sexually assaulted**.** That this funding is provided equitably to reflect the comparative prevalence of sexual assault between genders.

Recommendation 14: That the Queensland Government ensure that the existing and additional resources required to provide equitable sexual assault support services for women are not diverted into providing services for men.

Recommendation 15: That the Queensland Government recognise that as well as being a minority group of victims, men are also the majority of perpetrators of sexual assault. That the majority of male-targeted funding be directed toward prevention of sexual violence.

Recommendation 16: That the Queensland Government recognise the expertise of existing specific focus services to provide a range of appropriate responses which meet the diverse needs of women who have been sexual assaulted.

Recommendation 17: That the Queensland Government increase funding to the 5 specific focus sexual assault services to:

- Enhance their capacity to resource other services throughout the state to meet diverse service user needs.
- Enable them to respond to the identified increase in demand for services amongst women from specific target groups.

Recommendation 18: That the Queensland Government recognise the central role of community education and prevention activities in reducing sexual violence, and adopt a whole of government policy to address community attitudes which legitimise sexual violence.

Recommendation 19: That the Queensland Government continue to fund services which integrate community education and direct service provision.

Recommendation 20: That the Queensland Government commit to best practice in community education and prevention through:

- Adopting the National Association of Services Against Sexual Violence (NASASV) *National Standards for the Primary Prevention of Sexual Assault through Education*.
- Requiring that all funded community education projects meet these National Standards.

Recommendation 21: That the Queensland Government enhance existing best practice in community education through:

- Articulation of prevention activities in service agreements.
- Increased funding to all community-based services, to enable them to address the diverse educational needs of communities across Queensland.

Recommendation 22: That the Queensland Government adequately fund existing services to produce resources and provide other professional development activities across the sexual assault sector. That this includes funding regular, coherent, statewide training that draws on the expertise within the sector to further develop sexual assault professionals and other service providers.

Recommendation 23: That the Queensland Government:

- Recognise the central role of cross-sectoral links in enhancing service provision for women who have been sexually assaulted.
- Support the maintenance and further development of links between the sexual assault sector and service providers in the medical, legal and other social systems.
- Resource collaboration across the sector to enhance medical, legal and psycho-social responses to sexual violence.

Recommendation 24: That the Queensland Government adopt a statewide framework, policies and a whole of government approach to sexual violence that is consistent with the national plan, and informed by the perceptions of women who have experienced sexual assault.

Recommendation 25: That the Queensland Government recognise that sexual violence is more than an acute medical crisis and considers funding augmentation across portfolios such as Health, Justice and Communities.

1. Introduction

1.1 Aims of this report

This report proposes an evidence-based, holistic response to sexual assault in Queensland. It advocates a system designed to enable Queensland to move toward the reduction, and ultimate elimination, of sexual violence.

1.2 Report structure

The need for this report was originally driven by release of a review of Queensland Health responses to adult victims of sexual assault by KPMG, which proposed a single model of service for the sexual assault service delivery sector in Queensland. This report proposes an alternative service delivery system, which better addresses the needs of the Queensland community. Specifically, this report:

- Identifies the existing strengths of the sexual assault service delivery system in Queensland.
- Demonstrates the value of building on these strengths to achieve improved service delivery outcomes.
- Provides national and international evidence about successful service delivery strategies for people who have been sexually assaulted.
- Recognises the interdependence of prevention and intervention work, and the value of work with both recent and past victims/survivors of sexual assault.
- Demonstrates the importance of adopting a gendered analysis of sexual violence, and using this as the basis of a shared common goal for the service delivery system.
- Proposes an evidence-based, service delivery system based on best practice principles, to meet the varied needs of people who have been sexually assaulted.
- Demonstrates the need for a collaborative system of interdependent government and non-government services, each using different models of service according to the needs of particular communities.
- Acknowledges the particular needs of women from disadvantaged populations, who represent a significant majority of victims/survivors of sexual assault.
- Identifies the advantages of a planned approach to addressing sexual violence in Queensland.
- Advocates development of a coherent, *whole of government* policy framework, informed by available community and professional expertise.

For a more detailed critical analysis of the model proposed by KPMG, see the *Addendum* to this paper which is available as a separate document.

1.3 Report methodology

All 20 non-government sexual assault services in Queensland contributed ideas and evidence to this paper. Of the 20 services, 12 contributed financially to employ a consultant to gather ideas and write the report. These 12 services became the *Reference Group* for the project. The Reference Group appointed the consultant, designed the process for the project and identified the key questions to be addressed in this paper. The consultant articulated Reference Group ideas into 20 questions. These were grouped according to theme, and used as a consistent basis for all consultations - by workshop, phone interview and survey.

All 20 community-based sexual assault services were offered at least 3 ways to contribute to this paper. Every service contributed through at least 2 means:

- 6 of the 7 Brisbane-based services (and 2 non-Brisbane services) participated in a full day Consultation Workshop held in Brisbane on Thursday 15 April 2010.
- 9 of the 10 remaining regional, rural and remote services took up the opportunity to participate in a substantial (2 hour) phone interview.
- All 5 specific focus services participated in an additional face-to-face interview.
- 12 of the 20 services completed the survey (or equivalent) - to provide supporting evidence and/or additional arguments.
- 20 of the 20 services responded to a questionnaire (with 19 services completing the questionnaire itself and the remaining service contributing written comment on some of the questions).

The questionnaire was one of the outcomes of the Consultation Workshop[1]. A detailed questionnaire was designed and administered to generate both quantitative and qualitative data about the models of service and expertise of community-based sexual assault services.

Ultimately, the Reference Group determined the final content of this paper.

2. Report Context

2.1 Dimensions of the problem

Approximately 19,000 incidents of sexual assault were reported in Queensland in 2006[2]. A major ABS study found that only 15% of women who experience sexual assault report this to the police[3]. This is consistent with reporting rates for violence against women more generally[4]. It suggests that over 125,000 incidents of sexual assault are likely to be perpetrated against women in Queensland each year. Further, evidence suggests that *50% of victims of sexual assault may experience symptoms across their whole life span*[5].

The most recent available statistical information on sexual assault is published by the Australian Centre for the Study of Sexual Assault. Studies have found that:

- 19% of all women report having experienced sexual violence since age 15 (compared with 5.5% of men)[6].
- 12% of all women report having been sexually abused before age 15 (compared with 4.5% of men)[7]. (Another major study found that 18% of women report being sexually abused before the age of 16[8].)
- 12% of women report experiencing sexual violence by an intimate partner over their lifetime[9].
- 27% of women report sexual violence by others over their lifetime [10].
- 1% of women report being raped by a stranger over their lifetime [11].

The potential demand for both crisis and ongoing support services is overwhelming. Current resources are patently inadequate to address the size of this problem. It is hardly surprising that Queensland sexual assault services consistently report an inability to meet demand for both prevention and intervention services.

2.2 Overview of national best practice

The National Association of Services Against Sexual Violence (NASASV) has produced 2 sets of National Standards which identify best practice in sexual assault service delivery in Australia - the *National Standards of Practice for Services Against Sexual Assault* and *National Standards for the Primary Prevention of Sexual Assault Through Education*[12].

The Australian and Victorian governments have led the way in articulating best practice in responding to sexual assault into a whole of government plan. Seven (7) elements of best practice which are common to both the Victorian and national plans to address sexual violence are:

1. The importance of clearly identifying sexual violence as a gendered issue, and developing policies, strategies and a body of practice driven by a gendered analysis[13].
2. The central, underpinning role of human rights principles and obligations, when addressing sexual violence[14].
3. The need to increase collaboration between key stakeholders at a local level, to provide more integrated and accessible services[15].
4. The need to acknowledge and articulate the expertise and contributions of non-government organisations, and further develop successful models of practice[16].
5. The critical and complementary role of primary prevention in the overall response to sexual violence[17].
6. The importance of developing and delivering tailored and accessible intervention and prevention services at a local area[18].
7. The need to provide realistic and sustained funding for community-based sexual assault services[19].

The common themes in these government plans, and the National Standards, have driven this proposal for an alternate sexual assault service delivery system for Queensland. Each is explored in detail in this report.

3. Toward the Elimination of Sexual Violence

The primary aim of the sexual assault service delivery system in Queensland should be to contribute toward the reduction, and ultimate elimination, of sexual violence across the state.

This requires primarily viewing sexual assault as a social issue, rather than an individual or medical problem. It demands recognition of the overwhelming evidence that sexual violence is gender based - that the vast majority of people who are sexually assaulted are women; that the vast majority of perpetrators of sexual assault are men. It requires resource allocation consistent with this evidence.

Queensland sexual assault services envisage a human rights-driven service delivery system, which recognises the integral role of sexual violence. A sexual assault service delivery system will be most effective and efficient if it includes sophisticated, evidence-based, prevention and community education strategies.

Queensland sexual assault services are committed to a service delivery system based on recognised best practice in responding to the diverse needs of people who have been sexually assaulted. The system would enable provision of responsive services which address the human rights and individual needs of people who have experienced recent or past sexual assault, using a variety of responsive, evidence-based, intervention strategies.

Queensland needs a service delivery system which values and accommodates many different models of service; where services are encouraged to continually grow and improve their service delivery and responsiveness to community needs. An efficient and effective sexual assault service delivery system would recognise the different contexts and needs of different communities and community members. Both government and non-government services would be customised to needs of the particular communities they serve.

An efficient and effective service delivery system would recognise the positive working relationships that exist across the sector, and the benefit of these for the whole Queensland community. It would value existing networking between services, and would encourage and support continued development of collaborative, interdependent relationships.

This flexible, adaptable, responsive system would receive *whole of government* support. The Queensland Government's commitment to addressing sexual violence would be reflected through the development and implementation of a comprehensive statewide plan. All relevant government departments would contribute to a pool of funding sufficient to adequately and securely fund services, proportional to the magnitude of this problem, throughout the state.

An optimum service delivery system would build on the existing expertise in the sector. Services would be adequately resourced to deliver both prevention and intervention activities, and to contribute to mutual professional development and continuous quality improvement across the sector. Services would be adequately resourced to contribute to developing a new generation of Queensland professionals, well educated about sexual violence and its causes, and responding to sexual assault.

The design and management of the Queensland sexual assault system would be informed by the expertise of victims/survivors of sexual violence. It would encourage and support the involvement of all services in acting to reduce, and ultimately eliminate, sexual violence in Queensland.

Recommendation 1: That the Queensland Government commit to a comprehensive response to sexual violence involving collaboration with victims/survivors, sexual assault services, health workers, police and the criminal justice system in order to develop safe, meaningful and effective programs for a diverse range of victim/survivors (particularly relevant to rural and remote areas).

4. Solutions - A Gendered Analysis

FACT:	Women are significantly more likely to experience sexual assault in the course of their lifetime than men[20].
FACT:	1 in 3 women reported having unwanted sexual experiences in childhood compared with more than 1 in 6 men[21].
FACT:	1 in 5 adult women experience sexual coercion, compared with 1 in 20 adult men[22].
FACT:	National recorded crime statistics show that more than 80% of sexual assault victims are female[23].
FACT:	The Queensland Police report that in 2006-2007, 82% of victims of reported sexual offences were women[24].

Any woman can become a victim of sexual assault. Sexual *violence knows no geographical, socio-economic, age, ability, cultural or religious boundaries. Most commonly, women experience violence at the hands of men they know, often in their own homes, often repeatedly.*[25] The overwhelming majority of violence in Australia is perpetrated by men against women[26].

Violence against women is driven by the unequal distribution of power and resources between women and men and adherence to rigid or narrow gender roles and stereotypes. This reflects gendered patterns in the prevalence and perpetration of violence[27]. Violence against women is facilitated by, and reinforces, unequal power relations between women and men, sex discrimination and gender stereotyping. A gender-based analysis recognises sexual assault is about power, not sex. Social and cultural norms drive sexual violence. Social institutions and structures serve to legitimise sexual assault. It is impossible to effectively prevent violence unless these underlying factors are systematically addressed[28]. If the gender-based nature of sexual assault is not acknowledged, sexual assault services will merely respond to victims of sexual violence without acting to reduce or eliminate sexual violence.

The Victorian and Australian Governments have taken the lead in integrating a gender-based analysis into policies and strategies to address sexual assault. According to the former Prime Minister, Kevin Rudd:

> *As a nation, the time has well and truly come to have a national conversation – a public national conversation, not a private one – about how it could still be the case that in 2008 so many Australian women could have experienced violence from their partner…*
>
> *It is my gender – it is our gender – Australian men – that are responsible.*
>
> (Cited in *Time for Action* 2008[29], p 12)

The National Plan *focuses primarily on the rights of the majority of victims of domestic and family violence and sexual assault, women and their children*. A gender-based analysis underpins the Plan's key directions. Similarly, the Victorian Premier John Brumby says:

> *This major new 10-year plan sets out short, medium and long term measures to reduce levels of violence against women by challenging its underlying causes.*
>
> (Cited in *A Right to Respect* 2010[30], p 4)

In marked contrast, the vision for the Queensland Government's 5 year strategy to reduce domestic & family violence is expressed in gender-neutral terms:

> *All people, regardless of gender, age, ethnicity, sexual orientation or personal circumstance, are safe and live free from domestic and family violence in Queensland.*
>
> (*For Our Sons & Daughters* 2009, p 5)

The principles based on this vision are also entirely expressed in gender-neutral terms[31]. The strategy does not mention the phrase *sexual violence* once, nor do its strategies reflect the gendered nature of sexual violence. There is some overlap between family violence and sexual violence. *For Our Sons and Daughters* is relevant

to sexual violence perpetrated by a family member - which accounts for approximately 27% of reported sexual assaults[32]. While sexual assault is most commonly perpetrated by someone known to the victim, the majority of assaults fall outside this strategy.

Reduction and elimination of sexual violence requires a stand alone strategy to reduce sexual violence in Queensland. It is essential that the Queensland Government publicly recognise the gendered nature of sexual assault, and acknowledge that any effective strategy to address sexual violence must be based on a gendered analysis. The Australian and Victorian Governments' approach to violence should be reflected in Queensland Health services to address sexual violence. As one sexual assault worker described it:

> *There was a time in history where most people didn't survive surgery. This was due to the presence of bacteria. Once this was discovered, germ theory transformed surgical outcomes and people began to survive. If this evidence had been ignored, and science had continued to pursue other discoveries of modern surgery without eliminating bacteria, nearly all of them would have failed. It would not have mattered what other modern technology was implemented if the problem of bacteria was not addressed.*
>
> *Likewise if campaigns to eliminate sexual violence against women and children continue to focus on random acts of deviant behaviour or worse still, family dysfunction, entrenched attitudes of male entitlement to violate and exploit women and children will continue to thrive.*

A human rights driven approach to sexual violence creates a bridge between the <u>public</u> arena of attitudinal, policy and structural change, and the <u>private</u> sphere of individual counselling and support. A gendered analysis has implications for all levels of service design and practice. Services must have an explanation for the occurrence and nature of sexual violence in order to be able to conduct community education. This explanation directly affects the way services are provided to individual women, including decisions about the physical and emotional environment created, the therapeutic interventions used and the exercise of power in the course of service delivery. A critical element of feminist models of practice is their view of each service user as an active (not passive) participant in responding to her own circumstances.

Many women delay, or are inhibited in, disclosing sexual assault. This is often driven by a lack of physical or emotional safety. The physical and emotional environment of a service plays an important role in creating safety for service users. Some women survivors of sexual assault do not initially recognise the importance of women-only space:

> *It's interesting because we have women come to our groups who probably wouldn't have thought there was a need for women-only services until they came and then realised that 'actually this is why it's working for me. I've got this safe space and can share with other women who have experienced violence …'* (Interview cited in *Women's Health Matters*, p 70)

It is essential that services for women retain an autonomous, non-institutional, confidential and woman-orientated environment. Service users talk about the importance of service environments being *supportive* and *comfortable*. The concept of *comfort* can include practical, welcoming things, such as providing a nice environment. It can also encompass a way of working that ensures that women feel able to be themselves, be less embarrassed or self conscious, more relaxed, and more able to open up. Women use the term *support* to mean a safe and non-judgmental place, where they can *be themselves*, be understood and listened to; where they can express themselves and get support and encouragement from other women[33]. A women-friendly physical and emotional environment provides a platform for women to become empowered, engage with others, and develop confidence, greater independence and higher self-esteem.

Women-only space is a structural intervention to address the gendered nature of violence experienced by women. Women-only services are exclusively staffed by women. The value of services provided by women, for women who

have been sexually assaulted, has been widely recognised[34], even amongst women in the general public[35].

A gendered analysis also drives choice of therapeutic models. A perception of sexual assault as a *social problem*, rather than an *individual problem*, underpins the frequent use of group-based approaches in feminist services:

> *Joining with and dialoguing with multiple others who are similarly situated, on equal footing, and intent on empowerment help forge a positive identity and cut through alienation in ways that dialogue with a single counsellor cannot.* (Burstow 1992, p 64)

Many women who have experienced sexual violence become isolated. Women who have been sexually assaulted emphasise the benefits of being able to overcome their isolation, share their experiences together and explore how gender impacts upon their lives as women. Group participation can function as a catalyst for both personal and social change. The power of this connection with other women is illustrated through quotes from women who participated in a ten week support group at Brisbane Rape and Incest Survivors' Support Centre (BRISSC):

> *Getting together with other women and sharing stories has made me finally feel like I'm not the only one in the world. We are NOT 'mad' we are survivors! This is invaluable.*
>
> *Sharing with other women our thoughts and feelings has helped me to feel less isolated and more comfortable that I'm okay and worthwhile. I will be seeking out more support groups and social groups in the future.*
>
> *When I see my psychologist, I'm the one who is sick and the psychologist is the expert. In group I realised the other women were experts on what had happened to them and so I must be too.*

Similarly, a gendered analysis influences choice of counselling models, with a focus on intervention approaches that are client centred, holistic and emphasise empowerment:

> *… feminist therapy with a victim of sexual violence is to help her understand that such violence is a societal problem not just an individual problem and that sexual violence is reinforced by gender based differences in privilege and power that play out within interpersonal relationships. Feminist therapies also focus on survivors difficulties with guilt and self-blame in the long term, not merely the alleviation of psychological symptoms in the short term (Campbell, 2001). The findings of an early study (Hutchinson and McDaniel 1986) suggested feminist therapy was indeed more successful in reducing survivors' levels of guilt and self blame than traditional counselling. A more recent study (Morgan 2000) with survivors of childhood sexual abuse also demonstrated that survivors who participated in feminist therapy had greater improvements in depression, social adjustment, self blame and post traumatic stress than their counter parts in the control group.* (Astbury 2006, p10)

Recommendation 2: That the Queensland Government recognise that the structural, economic and cultural values of our society give power to men, making women more likely to be victims of sexual assault.

Recommendation 3: That the Queensland Government recognise the gendered nature of sexual violence and advocate and support a gendered analysis as a best practice approach to both intervention and prevention work.

Recommendation 4: That the Queensland Government acknowledge the inherent importance of *women's only space* to providing a safe and supportive environment to meet the physical, emotional and psychological safety needs of women who have experienced sexual assault.

5. Solutions - A Cost Effective Approach

This chapter examines the economic and social costs of sexual violence, and the interaction between sexual assault and other health and community issues. It identifies emerging national evidence about the most cost effective way to reduce these current and future costs – particularly, the importance of prevention activities and recognising the complementary roles of government and non-government services. The current and projected economic cost of sexual violence alone calls for a cost benefit analysis of service provision:

> *The cost of violence against women and their children to the Australian economy is estimated to be $13.6 billion in 2008-09 and, if there is no reduction in current rates, it will cost the economy an estimated $15.6 billion by 2021-22.*
>
> (Cited in National Council to Reduce Violence Against Women and Their Children 2009b, p 4)

Non-government services currently provide a range of customised sexual assault intervention and prevention services. Over many years, services have tested and refined a specialist body of knowledge and skills, and developed sophisticated models of service. As a result, community-based services can respond in an effective, flexible manner to the multi-faceted needs of people who have experienced recent or past sexual assault. Services work closely with a wide range of government service providers to address the various short and longer term needs of victims/survivors of sexual assault. In particular, services work in a collaborative, cooperative manner with Queensland Health and the criminal justice system to address the crisis needs of recent victims of sexual assault. Concurrent with this direct service delivery, community-based services continue to provide community education and prevention activities for their particular geographical or focus community. Services achieve significant efficiencies through their intervention and prevention services informing each other. The resulting mix in many workers' job description has played a key role in retention of experienced, specialised professionals in the sector.

The proposed model would result in loss of significant expertise from the sector. It could be expected to create a situation where integrated, community-relevant models of service would be replaced by generic approaches to prevention and intervention activities. The proposed discontinuation of services to *historic* survivors of child or adult sexual assault can be expected to result in compounded needs amongst survivors, which will increase demand for a variety of health and community services over time. Replacing the current multi-faceted approach to one primarily driven by the needs of the criminal justice system can be expected to increase the social and economic cost of sexual violence to the state into the future.

The most efficient and effective way forward is to recognise the cost-effectiveness of building on the existing competencies of the sexual assault sector to reduce the cost of sexual violence in Queensland and:

- Maintain a multi-faceted, community-based approach to intervention and prevention.
- Extend the capacity of the sector to engage in prevention and early intervention activities.
- Value the complementary roles of government and non-government service providers.
- Affirm and build on the current flexible, cooperative approach to service delivery.

5.1 Economic cost to the individual, community and nation

The potential economic cost of failing to address sexual abuse is frightening. The estimated national cost of violence against women and their children, in the absence of effective intervention, of $15.6 billion by 2021-2022, was determined by an independent economic analysis commissioned by the National Council to Reduce Violence Against Women and Their Children. This is more than the 2008 stimulus to address the Global Financial Crisis ($10.4 billion) and more than twice the cost of the Education Revolution ($5.9 billion)[36].

This analysis identified 7 categories which were used to determine the current and expected future costs of violence (including sexual violence) against women:

1. *pain, suffering and premature mortality costs associated with the victims/survivors experience of violence*
2. *health costs include public and private health system costs associated with treating the effects of violence against women*
3. *production-related costs, including the cost of being absent from work, and employer administrative costs (for example, employee replacement)*
4. *consumption-related costs, including replacing damaged property, defaulting on bad debts, and the costs of moving*
5. *second generation costs are the costs of children witnessing and living with violence, including child protection services and increased juvenile and adult crime*
6. *administrative and other costs, including police, incarceration, court system costs, counselling, and violence prevention programs*
7. *transfer costs, which are the inefficiencies associated with the payment of government benefits.*

(National Council to Reduce Violence Against Women and Their Children 2009c, pp 7-8)

Further, the report identified 8 groups which bear the cost of this violence: *victims/survivors; perpetrators; children; friends and family; employers; federal, state/territory and local government; and the rest of the community/society (non-government)*[37]. The National Council has estimated that at current rates, an estimated 750,000 women will report being a victim of violence in 2021-2022[38].

This cost is expected to be disproportionately a result of violence against disadvantaged women. The national study recognised the significant economic impact of violence on young women, women in rural and remote areas and economically disadvantaged women. Whilst the cost specific to these groups was too difficult to quantify in a rigorous manner, the study was able to project the violence-related costs for some groups of women. Without intervention, by 2021-2022:

- 26% of costs are expected to be a result of violence against immigrant and refugee women.
- 25% of costs are expected to be a result of violence against women with disabilities.
- 14% of costs are expected to be a result of violence against Indigenous women.

(National Council to Reduce Violence Against Women and Their Children 2009c, p 72)

Also of great concern is the projected *2nd Generation Costs* of the impact of violence on children. Without a reduction in violence against women, this is expected to account for 10% of the total cost of violence by 2021-2022.

5.2 Intersection with other health and community issues

There is a significant correlation between sexual violence and other social problems which cost the state many $millions. These include mental health issues, substance abuse, homelessness, criminalisation, physical health complaints, parenting issues, problems with interpersonal relationships, economic disadvantage, domestic violence and reduced levels of educational achievement, to name a few. For example:

- Up to 80% of women in the mental health system have experienced sexual violence at some time in their past[39].
- There is a strong established link between the severity of abuse and the probability of developing a mental illness in adulthood[40].
- 97% of homeless young women have been sexually assaulted[41].
- Up to 70% of women with drug and alcohol issues have experienced sexual violence at some time in their life[42].
- Approximately 89% of women in Queensland prisons are victims or survivors of sexual assault[43].

According to Australian National Council on Drugs:

> *Sexual abuse is strongly correlated with substance abuse and those who have previously experienced sexual abuse are over-represented among women seeking treatment for drug problems. Women who have not adequately addressed these issues in treatment appear to be more likely to relapse to drug use.*
>
> (Gowing et al 2001, p 9)

Similarly:

> *Inappropriate attempts to address issues of childhood sexual abuse by staff who are not professionally trained in the area of sexual assault may be counterproductive and contribute to relapse of problematic substance abuse.*
>
> (Swift et al cited in Stone & Clifton 2005, p 15)

This research demonstrates the critical role of specialist service provision to *historical survivors* of sexual assault. The primary health care system is not equipped to respond to long term needs of sexual assault survivors. It already has difficulty meeting demand, and does not have the capacity to meet the assault-driven needs of survivors of sexual violence. It is essential that ongoing therapy and trauma work for survivors of sexual assault is provided by practitioners with the specialised skills and expertise required to work through the impacts of past and recent sexual violence.

Workers in community-based services have the specialist competencies required to support women both immediately following sexual assault, and later in life. Given their long experience of working with survivors of past assault, non-government services can assist in the coordination of services for women with needs arising from past sexual assault. In particular, it is important that the needs of adult survivors of child sexual assault are reflected in policy development, organisational strategic planning and service delivery[44].

An investment in specialist, non-government services is cost effective for the Queensland Government. The earliest possible intervention by specialist sexual assault services would incur considerable savings for Queensland Health compared with the cost of providing ongoing services for people with multiple diagnoses of mental health, drug and alcohol and psychosomatic symptoms. These long term issues, resulting from a failure to recognise and address the impact of sexual violence, would unnecessarily clog up the health system[45]:

> *Providing support for women to address their longer term needs makes economic sense. If we don't have women-centred responses, these women will have difficulties functioning in the world … and end up with a life on pharmaceutical medication or non-pharmaceutical drugs. They will normalise reactions to sexual violation, rather than addressing them.*
>
> (Sexual assault counsellor, Far North Queensland)

Similarly, a reduction in sexual violence would significantly reduce the future costs to the state in a variety of portfolios including homelessness, child protection, economic development, criminal justice, juvenile justice and policing.

5.3 Cost benefits of a holistic approach

It has been widely recognised that an investment in prevention and early intervention is a cost-effective approach to sexual assault. Both the national and Victorian plans place a high priority on prevention and early intervention activities. The KPMG report also proposed that a focus on prevention of sexual assault be recognised as a *best practice principle* by Queensland Health, and that this be reflected in the underpinning policy for sexual assault service delivery[46].

The Victorian Government has recognised that community-based services have led the way, in both responding to violence against women and developing preventative strategies:

> *Their expertise, commitment and long experience in communicating issues of violence against women, creating and strengthening partnerships with generalist agencies, and translating specialist knowledge into 'mainstream' models of practice, will be invaluable as we move forward.* (*A Right to Respect,* 2010[47], p 19)

Further, the Victorian Government has acknowledged that the evidence shows that:

- Prevention policies are most effective when they are coupled with community based programs and strategies[48].
- Primary prevention is a critical and complementary component of an overall response to the issue of violence against women, which includes ongoing development of sexual assault service systems[49].
- Primary prevention efforts must include the provision of appropriate and supportive responses to women who are already experiencing violence[50].
- Local leadership is crucial for prevention to be effective, particularly to drive change on the ground. While a state plan can help to coordinate and consolidate prevention, locally-based and locally-organised actions are fundamental for achieving real change[51].
- Sexual assault services have developed an effective range of prevention strategies alongside vital crisis and support services, which form an important foundation for primary prevention (and have helped to shape the evidence base for policy)[52].

These findings are directly transferable to Queensland. Queensland sexual assault services have played a key role in prevention and intervention activities for many years. Community-based services have developed a rich variety of models, approaches and tools - many of which are customised to the needs of particular geographic and cultural communities. Concurrently providing both intervention and prevention has contributed to staff retention (particularly through reducing the risk of burnout) and a culture of continuous growth within services.

Non-government services overwhelmingly meet the best practice criteria set out by KPMG. Services are delivered by specialist professionals, with the capacity to provide a wide variety of prevention and intervention activities. Services are located within community organisations with the capacity to respond quickly and flexibly to address emerging problems and changing community needs. Non-government services provide a comprehensive range of support strategies to victims of both recent and past assault. They have demonstrated a capacity to provide services in a timely way, and provide identifiable entry points which make them accessible to women who have been sexually assaulted. Their victim-centred services are integral to the total service delivery system in Queensland.

A cost-effective approach to reducing sexual violence in Queensland would build on the existing expertise and strengths available within the sexual assault sector. It would recognise the integral role of non-government services in an articulated service delivery system which addresses both the crisis and ongoing needs of survivors of sexual assault, and the early intervention and prevention needs of the wider community.

Recommendation 5: That the Queensland Government analyse the social and economic cost of focussing on crisis services and identify opportunities to invest in prevention and early intervention.

5.4 Cost benefits of a collaborative system

Government and non-government services currently function as an articulated system - cooperating to optimise service delivery outcomes for people who have experienced sexual assault. Services work in partnership to address the varied needs of victims/survivors. Commonly, community-based services complement government medical and criminal justice services through providing information, practical assistance, continuity and decision-making support during the crisis period immediately following sexual assault. Community based services provide counselling and therapy to survivors of past assault, liaising with government services relevant to the longer term consequences of sexual assault in areas such as mental health, drug and alcohol, housing and child protection. Services across the sector are interdependent, and optimise their strengths through frequent inter-referral.

The Queensland sexual assault sector continually builds its collective expertise through mutual education, networking and support. This enables sharing of information, ideas, skills and knowledge. It reduces the risk of misdiagnosis and the consequent economic costs of sexual assault, particularly to the health system. It continues to contribute toward a multi-skilled workforce with the capacity to take a flexible, collegiate approach to cooperation and collaboration.

Recommendation 6: That the Queensland Government enhance funding and resources to existing programs that are currently working well before embarking on any new untested responses.

Recommendation 7: That the Queensland Government formally recognise the importance of networking and interagency collaboration and the central role these play in providing efficient, effective and holistic service delivery (particularly relevant to rural and remote areas).

6. Solutions - Access to holistic, appropriate support

This chapter focuses on the intervention services and interagency arrangements required to address the varied needs of victims and survivors of sexual assault. This includes the principles that should underpin sexual assault service delivery and the services required to address recent and past assault. It also addresses the specific needs of victims/survivors in rural areas and men.

> *Crisis services support people to exist; services to address past abuse supports people to live.*
>
> (Sexual assault counsellor, Far North Queensland)

> *It takes years to get up the courage to talk to someone about being sexually assaulted … and then it takes a lot more time to talk about how the assault has affected you over the years.*
>
> (Service user, age 34, Central Queensland)

Non-government services currently provide a wide variety of support services for both recent and past victims/survivors of sexual assault. Over time, services have developed customised models of service which enable articulation with government services, address service gaps and respond to the specific needs of their particular community. Some services provide both crisis and ongoing services. Some provide specialised services to groups of women at particularly high risk of sexual assault. Most regional, rural and remote services provide support to both men and women. Most urban services provide services for women. All are driven by the rights and needs of service users and a gendered analysis of sexual violence.

The proposed model would severely limit the range of services available, through primarily focusing on the collection of forensic evidence and establishment of pathways between medical, police and justice responses, in response to recent sexual assault. Services would generally be based in hospitals, and would mainly provide short term medical and counselling services using a medical model. This limited focus would not address the needs of the majority of current service users. It is inconsistent with Queensland Health Interagency Guidelines and best practice advice.

A small percentage of recent victims of sexual violence present at hospitals or police stations. The proposed model does not include strategies to increase these numbers or address current barriers identified by service users. These include fear of disbelief by the police and legal system; anxiety about lack of control over the process and exclusion from decision-making; and past experiences of failure by authorities to address individual/cultural/language needs. It is unclear how the proposed services would address the immediate needs of victims whose assault falls outside the narrow definitions of the criminal code; victims who do not wish to report the offence or participate in forensic examination; victims located in areas far from a major hospital; and victims who are uncomfortable approaching government institutions. It is unclear how the privacy of victims would be protected and how the environment would be made safe for women service users. The proposal fails to identify how the non-medical crisis needs of victims would be addressed.

The model also fails to recognise the value of addressing the needs of survivors of past assault; the high levels of cooperation and collaboration which currently underpin service delivery; and the unique contribution of community-based services to addressing the needs of service users.

The most efficient and effective way forward is to build on the existing evidence of effective practice in the sexual assault sector and:

- Support the implementation of best practice in crisis and ongoing sexual assault intervention.
- Enable existing services to maintain and extend successful intervention strategies.
- Affirm the central role of interagency collaboration in providing holistic sexual assault services.

6.1 The rights and shared needs of service users

International human rights instruments, to which Australia is a signatory, are universally agreed that everyone is entitled to live a life free of sexual violence[53]. Further, a variety of international agreements oblige states to implement *special concrete measures* to redress any human rights violation or form of discrimination against people on the basis of gender, race or disability[54]. Taking an equitable approach to service provision for people who have been sexually assaulted is not only permissible - it is essential if the rights of those groups most affected by sexual violence are to be addressed. These rights are reflected in *Time for Action* - the emerging national plan to address violence against women and children across Australia[55].

Clear evidence of the needs of people who are sexually assaulted have emerged over many years of research and service provision. Some common needs apply, regardless of whether someone has been sexually assaulted recently, or in the past. In short, everyone who has been sexually assaulted needs:

1. **To be believed**: Social and cultural messages suggesting that anyone who is assaulted must have *asked for it*, are alive and well in Australian society[56]. It is critical that people who have been sexually assaulted are believed and respected, and that their experience is validated, in throughout the sexual assault service delivery system.
2. **To take control:** Sexual assault involves the perpetrator taking control over their victim. Loss of control and a sense of powerlessness is fundamental to the experience of sexual assault. Regaining a sense of power over one's life is central to effective recovery. It is therefore essential that service users have optimum choice, power and control at all stages in the support process.
3. **To access information:** In order to be able to make choices, people who have been sexually assaulted need clear, accessible information relevant to their individual priorities and needs. Regardless of how recent the assault, people typically need information about legal, medical, mental health, practical support, counselling, social and other options, choices and services.
4. **To feel safe:** Different people have different safety needs. Immediately following assault, and sometimes in the long term, access to physical safety is a driving need. Most women who have been sexually assaulted feel unsafe in the presence of men, particularly men in positions of power and authority.
5. **To have privacy:** Many people find sexual assault difficult to disclose, particularly where the perpetrator was a family member, or someone they knew. The need for privacy includes being able to access services without being seen entering a named *sexual assault* service.

These needs are well reflected in the current Queensland Health *Interagency Guidelines*, which provide a valuable aspirational framework for sexual assault service delivery in Queensland. The overarching principles of the Guidelines include:

- All services will focus on the safety and physical and psychological needs of the victim;
- The victim's right to privacy and confidentiality will be respected at all times;
- Comprehensive information about all processes and options will be offered to victims in a way which is non-judgemental, appropriate, clear and sensitive to the victim in terms of language, culture, age, disability, gender, sexuality and location;
- The victim's informed decision will be respected at every stage of the process;
- The victim's sense of personal control will be supported and encouraged;
- All relevant agencies will work collaboratively to provide clear up to date and comprehensive information about other agencies and will facilitate access to those agencies and services on request;
- All agencies will ensure documentation and records are prepared in accordance with health, police and legal requirements and the need for confidentiality, security and choice.

Queensland sexual assault services strongly support these principles, which are key elements of this proposal.

6.2 Access to a complete service

> *Sexual assault is a significant issue that requires a coordinated response to manage the multiple needs of victims.* (KPMG 2009, p 1)

It is important that a service delivery structure is designed to be responsive to the potential demand and shared needs of people who have been sexually assaulted. Consistent evidence indicates that less than 10% of people seek medical assistance immediately following sexual assault[57]. Very few seek support services within the first 72 hours, 20-30% seek help within 2 weeks of an assault and 70% - 80% present for the first time more than 2 weeks following an assault[58]. At least 50% of people who are sexually assault will experience symptoms later in life[59]. Therefore, a best practice response would provide easy access to:

1. Crisis services designed to meet the range of needs commonly experienced by both reporting and non-reporting victims of recent sexual assault, and,
2. Ongoing support services for survivors of past sexual assault.

This range of needs is currently addressed through a variety of government and non-government services in Queensland. These services collaborate, often closely, to seek to ensure that the full range of needs of survivors/victims of sexual assault can be met. Interagency cooperation has been critical to optimising the effectiveness of limited resources to address the varied needs of service users, particularly in rural and remote areas. Networking and interagency collaboration directly impact service delivery outcomes, and play a central role in both the quality and quantity of service provision available to people who have been sexually assaulted.

One of the characteristics of trauma, is that people find it difficult to think clearly. Recent victims of sexual assault are generally in a traumatised state. People with a past history of sexual assault can be unexpectedly re-traumatised - often through seemingly unrelated experiences - and typically experience the same symptoms of trauma as those who have been assaulted recently. It is therefore important that a variety of entry points are readily available to sexual assault services, including: a 1800 number, hospital, police and community-based services.

Entry points are not simply physical locations. They are a point of communication that links people who have been sexually assaulted with the information and responses they require across all relevant human services. Many people who have been sexually assaulted do not identify their situation as a *medical* crisis and do not consider a hospital the most likely source of support. Similarly, if their first thought is not to pursue charges, they are unlikely to consider a police station the most likely source of support. Non-government services are often the *first point of call*, due to their visibility - particularly in rural and remote communities.

The 24 hour availability of the Statewide Sexual Assault Helpline 1800 number is a particularly important entry point. It is critical that this crisis service is available to provide timely information about sexual assault and the full range of service options available to meet the varying needs of people who have been sexually assaulted. Extensive marketing of the service would fulfil a dual function - providing both a source of information for potential service users and a means of challenging unacceptable community attitudes about sexual violence.

Provision of holistic support services for people who have been sexually assaulted, both recently and in the past, is fundamental to effective service delivery. This feature of the sexual assault service delivery system funded by Queensland Health has worked well, and has been a key element of a successful response to the needs of people who have been sexually assaulted.

Collectively, services should be able to address the shared, and individual, needs of people who have been sexually assaulted. These may include forensic services, practical help, police services, emotional support, legal help, peer support, medical assistance, counselling and therapy. It is critical that service provision is driven by the needs of service users, rather than systemic imperatives (such as the collection of forensic evidence). Women in the groups at highest risk of sexual assault commonly have adverse experiences of hospitals and/or police. It is therefore imperative that specific focus services exist which can support women in accessing mainstream services, or provide services directly

to these women. It is equally important that service providers are well trained, and equipped to respond appropriately to the varied needs of different victims/survivors.

Recommendation 8: That the Queensland Government provide increased funding to the Statewide Sexual Assault Helpline to:

- Enable provision of a 24 hour service.
- Enable comprehensive marketing of the service to maximize community access.

6.3 Access to service choice

In a 2009 online survey of over 500 people[60], respondents were asked: *Indicate how important or not important you think the following support services are:*

- 84% of respondents considered sexual assault services located in the community *extremely important*
- 79% of respondents found women only services *extremely important*
- 63% of respondents considered sexual assault services located in hospital *extremely important*
- 60% of respondents considered men only services *extremely important*
- 46% of respondents considered services for men and women (mixed) *extremely important*

Overall most types of support services listed were rated as *extremely important* or *important* by 80% or more of respondents.

The current mix of government and non-government services in Queensland is a key strength in providing a range of options for victims/survivors of sexual assault. Different people have different needs at different times along their *sexual assault survival journey*. It is therefore critical that, collectively, sexual assault services can meet service users at their current point in the journey, and respond to their needs - rather than providing standardised, prescriptive services. Service users must have access to services which provide a variety of types of services, with a choice of models, informed by specialist sexual assault knowledge, which provide follow-up and are sufficiently flexible to respond to service users' individual needs. Best practice in sexual assault intervention requires that service users have maximum possible control over the type of intervention, the pace of the intervention and the environment in which the intervention occurs. It is essential that services are delivered in a manner that respects the privacy and confidentiality of service users and responds to their sense of safety. Community-based services play a central role in providing *victim-focused* services with a flexible, *holistic* approach to service delivery, as advocated by the National Plan[61].

It is important that a gendered analysis of sexual violence underpins direct service provision. For many women, service provision by men, or even the presence of men in the service delivery environment, can parallel the violence they have experienced and function to re-traumatise women. Most women prefer to address their sexual assault experience in a *women only space*. The sense of safety provided by a feminist counselling framework has been identified as most useful by victims/survivors[62].

Choice of services is particularly important for women from disadvantaged social groups which experience high rates of sexual assault. Many of these women have had adverse experiences of government systems, and are generally unwilling or unable to access government-based services. Specialist community-based services often offer their only access to sexual assault services. Specialist services can play a critical role in supporting these women to access other services, advocating to ensure that their needs are met and providing professional development to other service providers.

Most women who are sexually assaulted, have limited economic power, and do not have the choice of purchasing support services to meet their needs. It is therefore essential that services are provided free of charge, that the sexual assault service delivery system is client-driven and that it provides genuine choice of services.

Recommendation 9: That the Queensland Government continue to engage both government and non-government service providers in order to address the diverse needs of people who have been sexually assaulted, recently or in the past.

6.4 Responding to crisis needs

The earlier an appropriate, specialist intervention occurs following sexual assault, the lower the risk of negative long term consequences - for the victim, their family, their community and society more widely. High health and other costs are associated with the long term consequences of unresolved sexual assault. Provision of responsive, flexible, holistic crisis support services is an investment in the health and future productivity of large numbers of Queensland survivors of sexual assault.

Sexual violence is a social problem that requires a response that is respectful; validates the person's experiences of sexual trauma; reassures them that their reactions to the trauma are normal; and assists them to recover at their own pace. Many victims of sexual assault have absorbed social and cultural messages that suggest that sexual assault is the victim's fault. Wherever a woman first presents for help, it is critical that service providers provide timely support which is appropriate to a crisis situation, and includes reassurance that the assault is not her fault.

Access to crisis support in the 72 hours following sexual assault is important. Intensive support can help service users *recover mastery over their lives*[63]. It is particularly important that the victim is given maximum possible control over the situation. The National Association of Services Against Sexual Violence (NASASV) National Standards identify the importance of the person being in control of the process and being recognised as the expert of their lives and the consequences after an assault[64]. The sooner the person has control over their own body and decision making, the better their prognosis for recovery. Crisis needs include support during the decision making process, and may include individual advocacy to access services to meet needs.

In order to make the best possible decisions, people who have been sexually assaulted need access to information. Some areas people commonly wish to address are:

- Safety Issues - any physical or emotional safety issues they need addressed. (These can be as varied as who they prefer in the immediate environment, the safety of other family members, or migration issues.)
- Practical support needs - including arranging access to money, transport and housing.
- Forensic issues - whether they want access to a forensic or *just in case* examination. (This should include advice that participating in a forensic examination will not oblige them to report the offence.)
- Reporting options - whether they wish to make a police statement, or report through Project ARO.
- Medical needs - any primary health care issues, including sexual health needs, they need addressed.
- Personal support needs - whether they want any of their friends or family available for support; need support to decide whether to tell friends/family; or need help disclosing to friends or family.
- Counselling options - for both immediate crisis support and longer term counselling.
- Privacy/confidentiality needs - whether they want information about how their private details will be stored, by the service itself or within the legal or medical systems.

Real choice of action and control over the process requires access to clear information relevant to the person's individual priorities and needs. It includes a willingness to discuss the possible immediate and longer term consequences of decisions. A key element of optimising victims' control in the decision making process, is the availability of a *just in case* forensic examination with delayed release to the police. This enables victims of sexual assault to make an informed choice as to whether to pursue charges following the initial trauma period.

All interaction with victims of sexual assault must be focused on their individual perceptions and needs. Services must be sufficiently flexible to respond to disparate individual needs. (For example some women have needed to bring their dog, talk with an Indigenous worker or have access to appropriate, professional interpreters.)

Specialised crisis support must be driven by the person and use a non-judgmental approach.

All professionals working with people who have been recently sexually assaulted should have the basic core competencies required to respond effectively to victims and meet the overarching principles of the Interagency Guidelines. All should have a sound understanding of trauma and its possible behavioural consequences. All should have a sound understanding of the causes and consequences of sexual assault, in particular the gendered basis of sexual violence and the implications of this for service delivery. This includes understanding the possible re-traumatising effects of forensic examination, particularly if undertaken by a male doctor. All professionals should be skilled in cross-cultural work and have the capacity to respond to people from any minority or disadvantaged group appropriately. All should treat each situation as serious and respond with proper gravity, regardless of the evidence and potential for prosecution. All should demonstrate that the person is believed, and validate both the experience, and person's responses to it.

These competencies are particularly important for medical personnel providing professional services for victims of sexual assault. Doctors and nurses are primarily trained to respond to physical, rather than emotional, needs:

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

Emergency departments are driven by the imperatives of urgency:

> *People who come with a sexual assault situation are not given the space. A busy emergency department is not the place. A person waits in a room for isolation purposes. It's just not fair.* (Nurse in the Emergency Department of a Brisbane hospital)

It is important that the needs of victims of sexual assault are addressed in a more appropriate environment than a hospital emergency department. In Victoria and New South Wales, medical, legal and forensic services are located in an independently located, cottage-style facility on hospital grounds. This model might be transferable to the larger urban and regional centres in Queensland.

Immediately following sexual assault, victims typically experience shock, denial and/or a sense of numbness. Many people cannot remember details of this period. It is common for victims to forget information they have received whilst in a traumatised state. It is important that people receive the relevant information both verbally and in a hard copy form (in plain packaging) that they can take away. As one woman said:

> *… by reading that, I felt normal … I realised that I'm not going crazy!*
>
> (Service user, Central Queensland)

For some victims of sexual assault, crisis needs continue to emerge until the assault is resolved. For women who pursue charges, this may mean that the crisis stage is extended until a court verdict. This underlines the importance of providing court support to people who have been sexually assaulted, as part of the continuum of care.

It is essential that a high level of collaboration exists between medical, legal and other crisis support professionals. This will ensure effective inter-referral between services responding to different needs of the victim. Any conflict between professional roles and the needs of the victim must be addressed openly and productively in professional forums designed for this purpose.

Recommendation 10: That the Queensland Government commit to provision of crisis support services for victims of sexual assault, which meet recognised national best practice criteria and the overarching principles of the Queensland Health Interagency Guidelines.

Recommendation 11: That the Queensland Government ensure that, consistent with the Interagency Guidelines, victims of sexual assault are given the choice to have immediate forensic collection with delayed release to the police.

6.5 Responding to ongoing needs

Primarily or exclusively relying on a crisis response to sexual assault is unlikely to address the needs of the majority of people who have been sexually assaulted throughout Queensland. Most people who have been sexually assaulted do not seek professional help immediately. Whilst crisis support can improve the prognosis for recovery and quality of life of service users, many people who have been sexually assaulted are re-traumatised at some time in the future.

The majority of people requiring support will seek this some time after their assault. Most people do not seek counselling during the first 2 - 4 weeks following sexual assault. One community-based service has found that the most common presentation time is 12 months after an assault. Another service noted that even people who choose to report their assault typically take 3 - 6 months before recognising the full impact of the sexual assault and seeking counselling.

Following sexual assault, people commonly feel that they can (or should) get on with their life and put aside their assault experience. Many choose not to think about their experience of sexual assault, until imperatives in their life (such as resisting touch from their partner, or feeling unsafe and vulnerable in everyday settings) make it difficult to avoid. The effects of any trauma take time to become fully realised in a person's life. Consequent individual acknowledgement takes even more time. Realisation of the need for counselling (being unable to *cure self*) takes further time. A person needs to feel safe emotionally and physically, before they can address long term effects of sexual assault (or any other psychological trauma). This sense of safety is not usually present at the time of the assault.

Many women take a long time to disclose their sexual assault due to family or social pressure to remain silent. Some women take a long time to develop sufficient trust in a service to disclose their sexual assault. For example, a woman might present seeking parenting assistance, but upon further discussion it is disclosed that she was sexually assaulted as a child and is anxious about her own child being abused. This highlights the value of co-locating sexual assault services in a multi-service environment.

Some women don't recognise the impact of their trauma for many years. Trauma is cumulative, and an apparently minor event can push someone *over the tolerance threshold*. Services are increasingly working with women in their 70's and 80's who have functioned despite their abuse for decades. A critical event such as the death of a husband, or an apparently inconsequential matter, can result in serious symptoms.

Many women presenting for sexual assault counselling experienced sexual assault as a child. The effects of childhood sexual assault (CSA) can continue to surface throughout a woman's life. The longer term issues and needs of survivors of CSA are generally related to the degree of social and family support; whether their assault was believed; and the extent of the abuse. Many survivors of CSA have faced many years of abuse. Many women had no opportunity or support to disclose their experiences as a child. Amongst those who have disclosed their childhood experiences, many report not being believed by authorities such as police, teachers or courts. The long term psychological effects and wider consequences for these women's health and wellbeing are numerous.

Often an unexpected, and apparently unrelated, incident can re-traumatise a woman with a history of past assault. Acute symptoms may be brought on by an experience of loss of control; an experience of aggressive authority; having a

baby; entering a new intimate relationship; strip searching; an anniversary; death of the perpetrator; being sectioned; domestic violence; abuse of a child or grandchild; hospital treatment; a gynaecological/cervical examination; dental treatment; media stories about the rape/torture of women and children; sexual harassment or sexism at work; or a different and recent experience of violence as an adult. For women who experienced CSA, common re-traumatisation factors include: family celebrations, contact with a child the same age as when she was assaulted, and her daughter reaching the age at which the mother was abused.

The symptoms of unresolved trauma following sexual assault can appear similar to mental health issues. Common symptoms include:

- Loss of confidence therefore stability (eg. an inability to hold down a job).
- Disengagement from community, social networks and family (eg. withdrawal).
- Behaviour changes (eg. isolation or promiscuity).
- Depression, suicidal ideation / attempt / completion, self loathing or self harm.
- Diminished capacity to engage with family life (eg. difficulties with parenting; difficulties relating sexually with a partner).
- Diminished capacity to deal with day to day issues (eg. financial management).
- Health issues (eg. illness, sexual health problems, eating disorders, substance abuse).

In particular, an unresolved experience of CSA can affect all aspects of a woman's quality of life, social connections and participation in the workforce and community. Many develop symptoms such as self harming, substance abuse, suicide attempts and post-traumatic stress disorder (PTSD). All too often, these symptoms of past sexual assault are misdiagnosed as mental health issues. This highlights the importance of specialist sexual assault education for mainstream health professionals.

Any of these symptoms may initiate seeking help. Often, women seek help for the symptom, without recognising its cause. Acute symptoms can be as severe if they occur many years later, as if they occur in the days or weeks following a sexual assault. This is particularly evident amongst older women who were assaulted during an era when there were strong taboos around acknowledging sexual assault, and are only now disclosing their horrific experiences of 40 or more years ago.

At a practical level, many women who have been sexually assaulted, particularly those in populations with a high incidence of sexual assault, have limited financial power. Access to quality, free, specialist sexual assault services provides important protection against risk of misdiagnosis, and the consequent individual and social costs of inappropriate, ineffective treatment in the mainstream mental health system.

The needs of survivors seeking support for past assault are broadly similar those seeking crisis support - to be believed, to take control, to access information, to feel safe and to have privacy. The values driving provision of support are similar to those required in a crisis situation - working in a collaborative and empowering way, walking with the woman, validating her perception, providing a safe environment, and providing timely access to services.

One area in which the woman can readily take control, is in decisions about the counselling or therapeutic approach used. It is essential that specialist sexual assault counsellors are committed to holistic practice and women-centred interventions. In order to achieve this, sexual assault counsellors must have a wide range of tools and techniques and the capacity to apply these in an eclectic way. Non-government services in Queensland, and nationally, have played a key role in researching, testing and documenting successful approaches to work with women survivors. The range of methods found to be successful include narrative therapy, equine therapy, non-directive counselling, a variety of confidence/self esteem development tools, Indigenous healing programs, art therapy, peer group work, consciousness raising, expressive therapies, pamper/soft entry strategies, strength-based tools, gestalt therapy… The success of these approaches is reflected in the high rates of referral from government services (with every service having received referrals from Queensland Health, police and the Department of Child Protection) and fellow professionals (including doctors, nurses, social workers, psychiatrists, psychologists and lawyers)[65].

People who have been sexually assaulted may have very different support needs. Some find that 2 or 3 sessions of trauma-based work is all

they need; some need many months, particularly if they are amongst the 27% of women who report experiencing both adult and child sexual abuse[66]. It is important to recognise the complex nature of sexual violence and the very different impacts it has on different people. Ongoing support should not be time limited.

Recommendation 12: That the Queensland Government continue to support and resource sexual assault services to provide flexible, holistic, ongoing counselling to survivors of childhood and past adult sexual assault.

6.6 The critical role of regional, rural and remote services

> *There is evidence of a higher reported incidence of sexual assault and domestic and family violence in rural and remote communities than in urban Australia.*
> (Women Services Network 2000[67])

Service delivery models and approaches necessarily vary enormously across regional, rural and remote Queensland. Different services must fill different gaps, and the focus for community education must be modified to fit local social and cultural values:

- In one town, there's a proactive disability service and good links with parole and probation, but few other services. In another, there's an active Filipina community - but no interpreters.
- There's a town with a regional hospital, but few other community facilities.
- There's a mining town, where the local culture suggests that women should not be alone on the street after 6 pm.
- There are island resorts, where staff find it difficult to leave if sexually assaulted …cities, with a similar range of services to Brisbane …and towns with an established farming community and an emerging gay community.
- There are communities where police are supportive of women who are assaulted … and others where police will not transport a sexually assaulted woman to hospital.
- In one town all the service providers are *long termers*, meet regularly and often collaborate to address local needs.
- There's another where the sexual assault worker is unwelcome - because *it doesn't happen in our town.*
- One service offers 24/7 support … another tries to resource 8 towns in 3 days per week.
- In one city, a range of government and non-government staff who sometimes work with people who have been sexually assaulted meet regularly as a formal network, and collaboratively work to address service delivery issues … at another, senior hospital management will not allow staff to network.

It has therefore been important to develop models of service and collaborative arrangements customised to the specific context of each community.

Privacy and confidentiality are a driving concern in rural communities. The fear of being seen accessing services, particularly in small towns and Aboriginal communities, is common throughout Queensland. The arrival of a sexual assault worker in a community, in some cases, makes it difficult for service users to access counselling with privacy. A woman seeking help at the local hospital risks finding a neighbour on the reception desk. A fellow professional who has been sexually assaulted will only seek counselling if no client record is kept.

Regardless of the mechanisms used by different services, maintenance of absolute confidentiality is central to the credibility of services in regional, rural and remote communities. Community-based sexual assault workers in rural areas have developed a range of strategies to try to optimise their accessibility to people who have been sexually assaulted. Some services are located in anonymous locations in relatively busy streets. Some workers will meet women in public places, or their home (if this is safe and appropriate). Sometimes support is better provided by phone - if necessary, with a sexual assault worker from outside the area. At one service, if a staff member recognises a name, the coordinator may call the woman in advance to advise her of this, and decide how to best meet her needs.

It is important that people who are sexually assaulted in regional, rural and remote Queensland have access to both crisis and ongoing support services. Different models of service delivery suit the particular needs of different communities. In some communities, service users have access to hospital-based services but not services to address their non-medical needs. In others, non-government services can provide ongoing support and medical needs can be met by a GP, but there is no access to forensic services. In others, the only immediately available support is the police.

Women in rural and remote areas have overwhelmingly reported a preference for community-based delivery of sexual assault services. In communities where both hospital-based and non-government services exist, a non-government service in an independent location driven by a locally-appropriate model of service has proven most effective in meeting the majority of service user needs. This approach requires a high level of collaboration between services, to ensure effective inter-referral to enable service users to access services to address their full range of crisis and ongoing needs.

In many communities there is currently no funding to provide crisis services. In some cases, women must drive 5 or 10 hours to access forensic services (often accompanied by male police in order to preserve continuity of evidence). Here, services are interested in exploring new approaches to addressing the needs of service users. Different approaches to co-location of crisis and ongoing services in a community-based setting could be piloted. Crisis forensic, medical and legal needs could be addressed through keeping a forensics kit on-site. Police, medical and other service providers could meet the person who has been sexually assaulted at the service. Alternately, a forensic nurse could be located within the service or available on-call, and the impact of this approach on reporting rates could be assessed. (It is believed that a forensic nurse is qualified to complete all aspects of a forensic examination and that this is common practice in interstate and overseas jurisdictions.)

Given the limited service options in regional, rural and remote Queensland, a high level of interagency collaboration and cooperation is particularly central to successful service delivery. The few available services must function interdependently. High levels of cooperation are essential to sharing the functions required to meet the needs of service users. A flexible, collegiate approach to working has been found to be the most effective and efficient means to optimise services to people who have been sexually assaulted.

Development of strong, respectful working relationships is essential to this. This includes a high level of respect for service users' privacy. It is particularly crucial that information sharing only occur with each service user's fully informed consent, because of the additional sensitivities around privacy and confidentiality in rural areas, particularly in smaller communities. A flat collaborative structure contributes to building a genuinely collegiate approach, which is reflected in a *spread of care* between services. It is important that all service providers (police, Office of the Department of the Public Prosecutor, hospital medical staff and non-government service providers) work together to develop strategies to better respond to sexual assault; resolve referrals and inter-service role tensions; and provide ongoing mutual support and program monitoring. Networking plays a particularly crucial role in rural settings, and must be treated as *real work*, by non-government and government service providers alike.

6.7 Responding to men

> *All people should have access to appropriate, skilled, sexual assault services. But, currently, we can't even meet the needs of all the women who want our services. There's never been a time over the past 10 years when we haven't had women on our waiting list. I'm very passionate about this. For as long as we have women waiting for counselling, we can't simply extend our existing services to men. If Queensland Health want us to widen our target population, then they have to resource us to meet this need.*
>
> (Sexual Assault Counsellor, South East Queensland)

A total of 8 of the 20 non-government sexual assault services, currently provide support to men who have experienced sexual assault. These are largely in regional, rural and remote areas,

where men do not have ready access to the specialist services available in Brisbane.

Regional, rural and remote sexual assault services are very aware of the possible needs of men in their communities. Of the 11 services outside the greater Brisbane area, 6 currently work with men who have been sexually assaulted. In most cases, their capacity to accept male clients depends upon having suitable facilities. All services which support men have recognised the need to make arrangements to ensure women's sense of safety. Some services are located in organisations that provide services to both men and women (in areas other than sexual assault), and have arrangements in place. Others have physical facilities available which make it possible to work separately with men (eg. separate waiting areas, separate buildings, separate entrances, or a *downstairs* area). One appointment-based service 'blocks' time to ensure that men and women using the service do not meet.

Models of service relevant to women cannot be uncritically applied to work with men. In their feedback submission appended to the Spall-Watters report, Spiritus Kinections highlighted the importance of addressing the needs of men who have been sexually assaulted in a gender-specific way. The report advocates the need to design models of service appropriate to men, and argues that such services must *have a strong branding about being male focussed*[68]. The report notes, for example, men's preferences for different counselling approaches to women. Existing sexual assault services for women cannot simply be *extended* to include men.

Many community-based services report having waiting lists for counselling. For these organisations, extending their services to men would mean minimizing their capacity to support women victim/survivors. Further, to provide quality support for men, services would be required to reallocate staff training resources to develop competencies in working with men. Existing non-government services have developed a rich feminist analysis, which forms the basis of women-driven practice that has evolved over many years. Given the level of knowledge and expertise held within the sector, existing services are the best placed to respond to male victim/survivors. In order for this to happen significant additional resourcing and attention to service delivery models would be required.

Rural services currently providing services to men, report low demand (eg. one per month or one every 3 months). Men in Brisbane currently have access to gender-focused services, customised to meet their particular needs. It would be both inefficient and ineffective to replace work with women with services for men in any remaining urban services. Additional resources would be required to access appropriate facilities, undertake the training and development required and market services, in order to provide gender-appropriate services for men in any further rural areas.

Recommendation 13: That the Queensland Government make additional funding available to develop safe, ethical, professional services for men and young men who have been sexually assaulted**.** That this funding is provided equitably to reflect the comparative prevalence of sexual assault between genders.

Recommendation 14: That the Queensland Government ensure that the existing and additional resources required to provide equitable sexual assault support services for women are not diverted into providing services for men.

Recommendation 15: That the Queensland Government recognise that as well as being a minority group of victims, men are also the majority of perpetrators of sexual assault. The majority of male-targeted funding should be directed toward prevention of sexual violence.

7. Solutions - Responding Appropriately to Diversity

This chapter addresses the needs and rights of groups of women who experience particularly high rates of sexual assault. Whilst sexual violence is endemic among women of all backgrounds, some groups of women are at higher risk of experiencing sexual violence. These groups include, but are not limited to, Aboriginal and Torres Strait Islander women; refugee and immigrant women; young women; women with intellectual and learning disabilities; and criminalised women. These are largely disadvantaged women with complex, inter-related needs, who are often unwilling or unable to access mainstream services:

> *I was very scared about coming here and talking about things, but I was made to feel comfortable, wanted and important enough.* (Young service user, Zig Zag)

> *I've got a psych degree and counselling qualifications - but I've been through some pretty tough times in my own life and used lots of services, and I know that peer support was the most helpful to my recovery.* (Specialist sexual assault counsellor, Brisbane)

Meeting the needs of victim/survivors from higher risk populations requires sensitivity to the particular contexts within which these groups exist. All specialist sexual assault services are currently working to meet the needs of these groups. In doing so services require support and resources to further enhance the quality and appropriateness of the work they do.

The 5 existing non-government specific focus services have built a reputation over time, due to their knowledge base of needs and skills in relation to working with high risk groups of women. Specific focus services collaborate closely with other sexual assault services through accepting referrals, and providing individual support and advocacy to enable women to access mainstream services. Over many years, these services have built an extensive body of specialist knowledge, skills and resources which add value to the wider sexual assault sector. Specific focus services also enhance the capacity of non-specialist service providers to respond appropriately to the needs of disadvantaged women, through provision of professional education, training, publications, support and advice.

The proposed model would significantly reduce services to disadvantaged women. Many of these women have a long history of involvement with government institutions. Their high level of needs is a result of failures by mainstream systems in the past. Many have a history of institutionalisation (eg. child protection, mental health, criminal justice) and an adverse history with authority (in Australia or overseas). As a result, many women fear authority figures and have a fundamental mistrust of government institutions. A single entry point, via a government-run hub, would effectively preclude most disadvantaged women from accessing sexual assault services.

Disadvantaged women are even less likely than other women to report a recent sexual assault. For the few who would report, the proposed model would place disadvantaged women at increased risk of re-traumatisation, victimisation and systemic abuse. Following sexual assault, women face further compounded needs. These are commonly expressed through trauma-driven behaviour. Disadvantaged women repeatedly report that this behaviour is often misunderstood by hospitals and police. Under the proposed model, women would be at increased risk of ending up with a mental health record as a result of appearing confused or disoriented. Women would be at increased risk of a punitive response, even criminalisation, as a result of being substance-affected or angry. If a hub was the only available free service, more women would be at risk of misdiagnosis, and many would receive no service at all. And, obviously, the proposed single entry point would preclude services to women prisoners, since they could not attend a hub.

The most efficient and effective way forward is to build on the strengths of existing specific focus services, through improving their capacity to:

- Meet the increasing demand for services from disadvantaged women.
- Provide pathways for disadvantaged women to access non-specific focus services.
- Enable non-specific focus services to respond appropriately to the diverse needs of women.

Specific focus services are integral to a successful sexual assault service delivery system, and the ultimate elimination of sexual violence. The critical role of specific focus services is underlined by the national study on the economic cost of violence against women and their children, which found that a significant majority of victims of sexual assault are from disadvantaged populations[69].

Five (5) specific focus services are currently designed to work with women with pre-existing complex, inter-connected needs, which are exacerbated by sexual assault. By co-locating with other programs targeted at the same population of women, specific focus services can address these needs in an efficient and effective manner. These organisations create an environment which protects women's privacy, and where women are not forced to disclose their sexual assault until they are ready. This allows specific focus services to build trust, and address some of women's many other (often practical) needs, until women feel sufficiently safe to disclose and begin to address their sexual assault. The organisations in which they are located have the capacity to provide flexible, long term support to address some of women's multi-faceted needs, and have established relationships with mainstream services required to address other needs.

Specific focus services play a central role in preventing sexual violence, through providing education to their particular target community. They respond to the needs of women in the context of their whole life, including their family, caring and parenting responsibilities. They value women's personal support networks and, if the woman chooses, include them in the healing process.

7.1 Aboriginal and Torres Strait Islander women

Murrigunyah Aboriginal and Torres Strait Islander Corporation for Women, currently addresses the rights and needs of Indigenous women who have been sexually assaulted. Murrigunyah also resources and supports the sector to better respond to Indigenous service users. The KPMG report acknowledged that Murrigunyah does not appear to be adequately funded and supported to respond appropriately to Indigenous victims of sexual assault[70].

The majority of Murrigunyah service users are dealing with historical sexual abuse, often in the context of multi-generational trauma. Historically, a large proportion of Indigenous women have been victims of sexual abuse since invasion, and the impact of child sexual abuse has been widely documented[71]. The Australian component of a major international study of violence against women in 2002/3, found that Indigenous women reported 3 times as many incidents of sexual violence in the previous 12 months as compared with non-Indigenous women[72]. Indigenous women in remote areas are at even higher risk of sexual assault. National Council to Reduce Violence Against Women and Their Children notes that Indigenous women *are 35 times more likely to suffer family violence and sustain serious injury requiring hospitalisation, and 10 times more likely to die due to family violence, than non-Indigenous women*[73].

The *United Nation Declaration of the Rights of Indigenous Peoples*, articulates Australia's obligation to take measures to protect Indigenous women and children from all forms of violence (Article 22), using strategies implemented wherever possible through services driven by Indigenous people (Article 23) and to optimise the mental and physical health of Indigenous people (Article 24)[74]. Consistent with this, the National Council to Reduce Violence Against Women and Their Children reinforces that *The key message therefore to governments is that it is time for action to … Close the Gap for Indigenous women*[75].

Indigenous women need to have choice in accessing culturally appropriate services. Murrigunyah has found that the majority of Aboriginal women are most comfortable in a service run by Aboriginal women. The physical environment must be Murri-friendly - so women feel drawn in, connected and energised. The physical space must include the option of going into a counselling room or talking in safe outdoor spaces.

Most Indigenous women respond more positively to Indigenous, than non-Indigenous, counsellors. Seeing an Indigenous counsellor often leads to women choosing to participate in cultural healing and other ongoing programs. Indigenous women report feeling *shame, blame* and *fear*, and *being*

looked down on by non-Indigenous service providers. Indigenous women do not currently have sufficient access to Indigenous sexual assault counsellors.

Disclosure of sexual assault is often a particularly complex matter for Aboriginal women. Workers need a personalised understanding of the needs of different groups of Indigenous women, and their different levels of engagement with customs and norms. Some Aboriginal women are not able to discuss what has happened with their family, or tell particular people about their experience. If they tell a female family member and are not believed, they become doubly isolated. Many women need time and space before disclosing their sexual assault and building trust is critical to enabling women to disclose. Therefore it is essential that a service provides a safe place until women are ready to disclose their experience. If Indigenous women decide to report a sexual assault, they often feel more comfortable and are more likely to speak out and tell their story, when accompanied and supported by an Indigenous friend.

Client-focused approaches have been found to be effective with Indigenous women. Women's needs cannot be seen in isolation from their family and community. All the evidence demonstrates that services for Aboriginal women must address women's whole range of needs, in order to be successful. It is essential that the service is holistic, and has the flexibility to comprehensively address women's needs. A holistic approach includes supporting women, and encouraging them to look after themselves, so they can better care for their family, and should include areas such as diet, health, nutrition and lifestyle.

Co-locating a specific focus sexual assault service with other services for Indigenous women, makes it more viable to seek out the resources necessary to fill the gaps in women's needs which cannot be addressed using existing sexual assault service funding. Most of the women who present at Murrigunyah following sexual assault, are traumatised and on low incomes, and cannot move forward if any of their needs are missed. For example, if they cannot establish safe, secure housing they may be forced to return to living with the perpetrator of sexual violence. This may involve concurrently addressing sexual assault, advocating for the woman with mental health authorities, and accessing housing, income and childcare for the woman and her children. Often, this requires the dedicated time of 2 or more workers for a period of time.

The ultimate goal of any service for Indigenous women should be to enable women to achieve harmony and balance. Culturally specific healing programs need to be considered for Indigenous victims of sexual violence. These types of services are supported by the Australian Government and international bodies[76]. Murrigunyah is the only Queensland sexual assault service to offer culturally appropriate healing services and training around women's business - including Healing Circles, Stolen Generations workshops, Spiritual Healing and traditional ceremonies (Smoking Ceremony). Women's attendance rates at events such as these, and other workshops such as Mental Health workshops, have been high. Yarning Circles, in particular, are helping women build effective relationships and strong psychological health and strengthening women themselves, families, communities and inter-agency partnerships:

> *If Aboriginal and Torres Strait Islander people are to be adequately supported in their healing journey, four primary principles must be observed. First, we must focus on addressing the causes of community dysfunction, not its symptoms. Second, we must recognise the fundamental importance of Aboriginal and Torres Strait Islander ownership, definition, design and evaluation of healing initiatives. Third, and by extension, the way we design initiatives must be based on Aboriginal and Torres Strait Islander worldviews, not western health understandings alone. Finally, we must strengthen and support initiatives that use positive, strength-based approaches.*
>
> (The Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009[77])

Peer support is critical to building healthy communities. Murrigunyah is closely linked with other culturally-appropriate organisations. Services often work together in partnership to address the needs of women, their families and their communities - with a youth service providing support to the young person,

Murrigunyah providing *whole of family* support to female family members, and other services working with male family or community members. Young people may be particularly cautious about reporting to the police, particularly if they are vulnerable because they have outstanding warrants.

Community education is critical to building healthy communities. Prevention and early intervention should include women's rights in relation to sexual and domestic violence, sexual health information and police responsibilities. Police Liaison Officers should be involved to reassure women about reporting sexual violence.

7.2 Women from non-English speaking backgrounds (NESB)

The Immigrant Women's Support Service (IWSS) provides sexual assault services to NESB women (from age 15, including refugee women), and to mothers and carers of NESB children who have been sexually abused. The service conducts community education with NESB women and CaLD[78] communities. This includes identifying emerging information needs amongst NESB women, producing up-to-date relevant materials in many languages, and distributing over 4,000 pamphlets annually. According to KPMG, responses to victims from CaLD backgrounds are currently inadequate. Their report acknowledged that IWSS is currently limited in its ability to provide culturally appropriate supports or secondary consultation to services on a statewide basis within existing resources[79].

IWSS collaborates closely with other service providers, and endeavours to respond to the high level of demand for its specific expertise. This been acquired through over 24 years of direct intervention and prevention activities; participation in state and national research; and contribution to coordinated service systems across the multicultural service sector. IWSS develops and maintains professional resources which are used throughout Queensland; provides customised support and advice to other services on cultural and migration issues; and trains over 250 professionals each year.

The 2006 Census confirmed that 24.8% of all Queensland residents were born outside Australia. For a significant proportion of these, English is not their first language. Further, IWSS has observed that a significant number of people born in Australia to NESB parents experience similar barriers in reporting domestic and family violence and accessing relevant support services. Women from NESB report experiences of sexual assault during war/armed conflicts, during flight/escape, in refugee camps and in detention centres. It is estimated that the majority of refugee women and children have suffered repeated rape and sexual assault[80]. A 2005 study suggested that between 78% and 86% of women who came to Australia as refugees had been tortured or traumatised through sexual abuse[81]. The National Council has recognised that *Immigrant and refugee women are more likely to be murdered as a result of domestic violence*[82], including sexual assault.

Many immigrant women come from countries where the laws and cultures do not recognise a woman's right to control over her body, and where the victim of sexual assault is blamed and punished. 80% of Australians rated forcing a partner to have sex as *very serious* violent behaviour[83]. In contrast, many refugee and other immigrant women do not understand what *sexual assault* (or *counselling*) is in the Australian context. As a result, they often do not recognise their experience as *sexual assault*, or understand the services available. This underlines the need for *special concrete measures* to be taken to protect NESB women from sexual assault (as required under the *UN Declaration on the Elimination of All Forms of Racial Discrimination*[84]).

For many newly arrived migrants and refugees, information about Australian laws; definitions of domestic and sexual violence; and available support services are not widely known. Community education with NESB women forms an essential part of an adequate service. It is only after receiving cross-cultural support and information that some women seek services - for most, only after other basic needs of settlement are met[85]. Intensive community education and engagement is needed on issues related to domestic and sexual violence with CaLD communities, which often hold cultural values and traditions that foster violence against women and children that may otherwise remain unchallenged. Community education strategies must be developed with sound cross-cultural frameworks, and support a gendered analysis of

violence against women and children, in order to effectively and appropriately address these values and attitudes.

Many NESB women are fearful about disclosing sexual assault. Many are economically dependent on their partner or spouse and have limited access to the means of independence, including work or eligibility for income support. Many have a history of bad experiences of police in Australia[86], or their country of origin. For many, disclosure breaches cultural taboos, and women risk being ostracised by their community or blamed for the assault. Some risk injury or death. Women who are on Provisional Partner Visas (Subclass 309 and 820) are often intentionally misinformed about their immigration situation by their sponsoring partner or spouse. Women frequently report that they have been told by a violent or abusive partner that if they choose to leave the relationship they will be deported and forced to return to their country of origin, or that their children will lose Australian residency - lies which serve to instil fear, anxiety and confusion in women and may lead them to believe they have no choice but to stay in a violent relationship.

Women from immigrant and refugee backgrounds are less likely to receive appropriate assistance when they try to leave a violent relationship, than other women[87]. Many service providers lack the cross-cultural competencies required to engage with NESB women. Professionals commonly make assumptions based on their own cultural norms, without realising that these are not *universal norms*. Understanding of the relationship between the *logic* of thinking and culture is crucial, and if not attended to, may result in serious misunderstandings, conflicts[88] and actual harm to women. For example, IWSS has worked with women whose mental health was questioned due to lack of cross-cultural understanding.

Interpreters are rarely used, although IWSS has observed some improvement in the appropriate use of interpreters over the past 24 years. Service providers in Queensland are largely unaware of when to use an interpreter, how to use an interpreter and what constitutes an appropriate interpreter:

> A NESB woman with experiences of recent sexual assault and experiencing strong abdominal pain went to a hospital in an attempt to seek medical support. As she could not expressed her needs in English, she asked for an interpreter and showed the interpreter request card that she was advised to show in case of needing to communicate.
>
> The woman said: *A group of people gathered beside me talking among themselves for a long time. I did not know what was happening. Nobody said or asked me anything so I waited there for about a ½ hour and left.*
>
> Considerable support was needed from the cross-cultural worker to encourage the woman to access her local GP. She did not want to go to any medical institution as she did not feel they would be supportive of her needs.

Interpreters must be gender appropriate, confidential and culturally appropriate. For example, it is important to consider issues of confidentiality if an interpreter comes from a woman's own small cultural community, and an interstate interpreter may be required. Failure to engage appropriately with professional interpreters may have serious and lasting consequences for women and their children. Human rights violations may occur when basic access and equity is not met through the provision of a professional interpreter:

> An immigrant woman reported that she attended a medical appointment with her husband to have what she believed was a prenatal check up during her pregnancy. The woman spoke no English however her husband was a fluent English speaker. The husband interpreted during this appointment and it was only after the woman woke up following an anaesthetic that she realised that her husband had procured an abortion without her knowledge or consent. This caused significant grief and trauma.

At the other extreme, many workers in government and community support services are afraid to work with women from unfamiliar cultures. Some are aware of their own lack of cross-cultural competencies and readily refer women to IWSS; others only refer the most complex cases; and many fail to recognise the critical role of individual advocacy and trust building with NESB women. For example, practical support such as reading letters, ringing a doctor, or giving a woman a lift, may play a key role in a woman's empowerment and access to information and services.

Given the current limitations of other services, it is critical that specifically trained workers can advocate with and for women to have their individual and cultural needs met. A complete service for NESB women necessarily includes responding to the full range of issues impacted by sexual assault, through addressing women's own priorities, cultural and language barriers and complex needs. These needs typically include legal, immigration, housing, income and child-related issues.

7.3 Young women

Zig Zag Sexual Assault Service & Young Women's Resource Centre provides support to young women from age 12, and supporters of young women, including family, friends and other service providers. Zig Zag has built a profile amongst schools and other organisations working with young women (as far as possible within existing resources), and has developed a model of service which specifically addresses the unique situation of young women - including their practical constraints, and the fast-changing cultural context in which they live.

Zig Zag stays abreast of social changes amongst young people. This service has unique expertise about the needs of young women, which has been developed over many years and is subject to constant review. Zig Zag maintains a body of knowledge about youth culture, the changing nature of sexual violence, and specific issues faced by young women. It is important that professionals understand the context of young women's lives - particularly the racism and marginalisation faced by many and the diversity of sexual violence affecting young women - currently *sexting* and other coercion/ bargaining strategies.

Zig Zag provides professional development to other sexual assault services, and professionals and community members more widely, to enable them to respond appropriately to young women who have been sexually assaulted. The service provides up-to-date resources and shares information with other services, about the changing context in which young women experience sexual assault. Zig Zag also provides a focus from which community initiatives to prevent sexual violence against young women can be developed, implemented and driven.

A disproportionally high incidence of sexual violence is perpetrated against young women. This is largely due to young women being in the process of learning social norms and exploring sex and sexuality. For some, new-found independence also provides their first opportunity to report earlier child sexual abuse to someone they trust. Indications are that over 21,000 girls and young women aged 12 - 17 living in the wider Brisbane region have experienced childhood sexual assault, and over 21,000 young women aged 18 - 25 years in the region have experienced some form of sexual assault since age 18[89]. According to 2009 recorded Australian crime statistics, 25% of all recorded sexual assault victims were aged 10-14 years of age[90]. Recent statistics on reported crimes in Queensland reflect a similar pattern, with 47% of total victims being aged 10 - 19 years, and 66% of all victims being younger than 25 years[91]. Further, a 2000 study by the National Association of Services Against Sexual Violence (NASASV) found that over a 2 month period, 17% of people accessing sexual assault support services were aged 15 years or younger. The NASASV study also found that 40% of people contacting sexual assault support services reported childhood sexual assault as their *main presenting reason* for accessing the service[92]. In the 1996 *Women's Safety Survey*, over one quarter (27%) of women who reported experiencing sexual violence since the age of 15, also reported having experienced sexual abuse in their childhood[93], and the National Council has acknowledged that young

women experience higher rates of sexual assault[94].

The community recognises *youth* as a group with unique needs in many areas of their life. A clear gap exists in services to 12 - 17 year old young women who have been sexually assaulted (who currently account for 50% of Zig Zag referrals). Their needs are not readily addressed within the limited roles and functions of the child health, hospital, mental health, education and child protection systems. Zig Zag has found that service providers in these systems consistently say: *It's not my job.* The physical environments of most *youth services* are dominated by young men, and many youth workers do not have the expertise to address young women's sexual assault needs. As a result, few youth services in Queensland provide a safe place for young women who have been assaulted. Provision of devoted space for young women affirms their value, and is central to responding to young women's experience of sexual assault. Young women report that a *very friendly and open place* such as the environment at Zig Zag is important:

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

> *I love coming to Zig Zag. It helps me realise that I'm not so alone in the world; that others are going through the same as me.* (Young service user, Zig Zag)

Trust building with young women depends on a warm, inviting environment where they can be assured of confidentiality. In part, confidentiality is maintained if young women can approach a specialist service which is not labelled a *sexual assault* service. Zig Zag, for example, is a multi-purpose venue which young women could be entering for a number of purposes - such as using the library, accessing housing or attending a program.

Young women generally have less mobility than older women. Young women's hours of availability are limited because their whereabouts are tracked for most of the time - particularly by their family and school. Those who are experiencing family sexual violence are likely to be particularly closely observed, often by their perpetrator. As a result many individual young women have a very small *window of opportunity*, and can only access services from a single provider on a *drop in* basis.

Flexibility of service provision is critical to addressing the needs of young women who have been sexually assaulted. Workers must be able to provide outreach to young women - at their home, school or in public places. Going into young women's homes and schools (where this is safe and appropriate) also enables workers to develop a personalised understanding of each young woman's current environment and needs. The capacity to address other needs related to young women's sexual assault (such as help accessing housing) is particularly important where young women are being violated by their carer or another family member, and their home is unsafe. Workers must also have the capacity to recognise and address symptoms of sexual assault (such as suicidal ideation or self harm) and address these as part of a wider picture of the young woman's needs. Given that young women may only have the capacity to access a single service, it is essential that any service providers can take on multiple roles - counselling, community education, enabling peer support and advocacy.

Community education is integral to effective service provision to young women. Individual young women need access to *culturally-appropriate* information about their legal rights, ethical rights, and what they can negotiate with a sexual partner. Often, due to limited life experience and knowledge, young women do not know whether they have been *sexually assaulted* or not. Wider public education and prevention for young women must be expressed through *culturally-appropriate* social messages using media that is relevant to them such as the Internet, marketing or movies. Further, women in high need social groups (such as young African women, or mothers of daughters who have experienced child sexual abuse) need more specialised support.

7.4 Women with disabilities

Women working alongside Women with Intellectual and Learning Disabilities - Sexual Violence Prevention Service (WWILD) provides sexual assault services to women with

intellectual and learning disabilities, from age 15. The service focuses on early intervention and prevention with girls who will shortly leave Special Schools in Brisbane. WWILD also provides education and support for other service providers who work with women with intellectual and learning disabilities, with a particular focus on recognising women with these disabilities.

It is estimated that 2%-3%[95] of the Australian population have an intellectual disability. The absence of recent statistical data on sexual assault rates amongst women with intellectual and learning disabilities shows the low value placed on this group within Australian society. Social perceptions and attitudes toward those living with an intellectual disability increases their risk of sexual victimisation. This occurs through social isolation, dependence on carers and lack of understanding of what constitutes sexual assault. A 1989 survey of 158 adults with intellectual disability found they were 10.7 times more likely to experience sexual assault than members of the wider community[96]. Talking about women with disabilities in general, the National Council says: *Women with disabilities are more vulnerable to violence and often have fewer pathways to appropriate support or options to escape violence particularly when perpetrated by partners and/or carers*[97]. The United Nations *Convention on the Rights of Persons with Disabilities* also recognises that *women with disabilities are subject to multiple discrimination*, and asserts the need for special *measures* to ensure that their human rights are met, and the particular need for *all appropriate measures* to meet the varied needs of people with disabilities who are victims of violence[98].

Women with an intellectual disability can have particular barriers to disclosure. Women who seek assistance to deal with sexual assault vary in ability, from those able to live independently with little or no support, to those in institutional care. These women have a history of powerlessness from a lifetime of requiring at least some level of support. Those relying on care are particularly vulnerable if their experiences dismissed or disbelieved by those who care for them or those in authority. This situation is compounded in the (common) residential situations where the perpetrator is also the woman's carer. Many are unable to express their needs within the short time allowed for typical interviews, and will not disclose sexual assault in time-limited settings. Based on previous experiences, many will not disclose because they do not believe they will be heard and understood.

Women living with an intellectual disability are particularly vulnerable to abuse because they often have no social networks or supports. Many of these women are so desperate for affection and friendships that they accept behavior that, if they had examples of *good* relationships in their lives, would seem unacceptable. This is evidenced in *Gemma's* story (as told by a WWILD sexual assault counsellor):

> *Gemma* attends both counselling and group work at WWILD. Her anger and lack of social skills made her isolated and vulnerable to further abuse. Gemma's past experiences gave her limited social skills, which were usually displayed with physical and verbal aggression. Through attending groups, Gemma has been able to observe and experience respectful interactions. She can now, at times, initiate interaction with new group members, listen, share, and behave considerately towards others. It has been noticed at the group home where she lives that Gemma's negative behaviours that previously caused conflict with those she resides with, both staff and other residents, has changed. She is now also less vulnerable to predators as her social needs are being met and she is no longer desperate for friendship.

Experience of abuse often results in women expressing anger and being unable to view life from any other perspective than their own. These are also common behaviours linked to intellectual disability. For women with a disability who are sexually abused, these behaviours are *doubly* prevalent and often twice as strong.

Women with an intellectual disability tend to lack knowledge or understanding about their own sexuality or what constitutes sexual assault. WWILD provides an environment that is non-judgmental and removes the stigma of having an intellectual disability. It is essential that women who have been sexually assaulted don't feel that they have to *mask* their intellectual/learning disability; that they feel they can ask if they don't understand. Substantial time is needed to help

women develop concrete concepts round abstract ideas such as emotion recognition, self-esteem and relationships. Interaction with other women with an intellectual disability, free of the pressure to mask their disability, is often a helpful starting point to addressing the needs of women who have been sexually assaulted and providing ongoing peer support.

Both group work and individual therapy sessions have been found to be effective interventions with women with intellectual disabilities who have experienced sexual assault. Group work is a safe space for these women to gain and share knowledge that can help prevent sexual assault in the future. This is a key tool in work with this group of women, and is critical to normalising intellectual disability and women's response to sexual assault.

Early intervention plays a central role in preventing sexual assault of women with intellectual disability. WWILD works with young women in Special Schools in the Brisbane area. Community education and prevention focuses on senior girls, who are about to leave the relative protection of school and home (if they are not amongst the many who experience familial abuse). This includes learning about recognising emotions, different types of relationships (eg. kissing mum vs. kissing a boy; hug vs. cuddle), what constitutes a *good* relationship, stages in relationships and images/perceptions of their sexuality.

Providing education for sexual assault service providers is critical. Women with intellectual disability tend to develop a habit of masking their disability. Many are highly skilled at being able to pass as *non-disabled* in the wider world - they often appear to understand what service providers are saying, when in fact they are acting. Many women with intellectual and learning disabilities are institutionalised and comply with authority figures. They are at risk of saying and doing what they think authorities want to hear, rather than addressing their needs related to sexual assault. Others respond in an oppositional way toward authority figures. Without specialist, skilled support, these women may be misdiagnosed, penalised, or receive *assistance* that doesn't acknowledge or fulfil their needs. They are at risk of being labelled, resulting in an inability to access care, as demonstrated by *Patricia's* story (as told by a WWILD sexual assault counsellor):

> *Patricia* came to counselling with quite severe physical symptoms – slurred speech with lack of balance and co-ordination. She expressed anxiety about previous experiences when attending a public hospital. She told of being removed by security as a result of her behaviour. She felt that they don't listen and she told how she then gets frustrated.
>
> I offered to go with her to the hospital. When we presented at emergency and she gave her Medicare number, she was challenged about why she was there. This assertive challenge resulted in her becoming defensive, and she started to raise her voice and demanded to know why she couldn't see a doctor. I was able to intervene and prevent this escalating. With Patricia's permission I spoke to the doctor. Her file was labelled "alcoholic, violent and aggressive" but included no mention of an intellectual disability.
>
> A lifetime of masking her disability, and the difficulty in understanding what was required of her, had Patricia responding with fear and defensive behaviours. Specialist intervention allowed medical staff to have some understanding and gave Patricia a way to explain her fear and uncertainty.

One of the most critical areas of skills development for sexual assault workers and other service providers is early detection of women with an intellectual disability, particularly over the phone.

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

provide individual advocacy and support, which enables both the women and service providers to avoid these problems.

Women with intellectual disabilities have a sense of ownership of the WWILD space, and have individually and collectively developed trust in the organisation and its workers. Word of mouth is critical to accessing this hard-to-reach population, and the fact that women continue to use WWILD services despite staff changes, indicates the level of trust in the service as a whole within this population group.

7.5 Women prisoners

Sisters Inside provides sexual assault counselling services to women inside prison in South East Queensland - which necessarily means that the majority of counselling is for past sexual assault. Sisters Inside also resources and supports service providers working with criminalised women, particularly in rural and remote areas.

Sisters Inside is widely trusted and recognised amongst criminalised women. This level of credibility takes many years to build, given these women's experience-based mistrust of organisations. This has resulted from Sisters Inside's clear values/ethics, consistent model of practice, the appointment of peer/Indigenous staff wherever possible and willingness to have a long term relationship with criminalised women (as long as it takes).

Research conducted by Sisters Inside indicates that approximately 89% of women in Queensland prisons are victims/survivors of sexual assault – including rape and child sexual abuse[99]. According to a Queensland government survey, least 42.5% of women in Queensland prisons experienced child sexual abuse, with 36.5% of prisoners having been sexually assaulted before age 10[100]. Another Queensland study found that 70-80% of women in adult prison in Queensland were survivors of incest[101]. These findings are consistent with those from other Australian states and internationally[102]. Not only are women prisoners more likely to have experienced sexual assault - it appears likely that sexual violence plays a significant part in a woman's journey toward imprisonment.

Further, with significant increases in imprisonment of criminalised women in recent years, many women prisoners are also members of other groups at high risk of sexual assault. Indigenous women are highly disproportionally represented. In 2004 the rate of imprisonment of Indigenous women nationally was 20.8 times higher than for non-Indigenous women[103]. Women with intellectual or learning disability are highly disproportionally represented. Studies have shown that up to 30% of women prisoners have intellectual disability[104]. Young women are disproportionately represented. As at 30 June 2005, 74% of women prisoners were aged 20 - 39 years, and over 40% of women in prison in Queensland were under 30 years old[105]. Imprisoned NESB women are at high risk of trauma. The Anti-Discrimination Commission Queensland raised serious concerns about the impact of prison practices on CaLD women, particularly NESB women[106].

Imprisonment frequently re-traumatises women with a history of sexual assault. Acute symptoms are commonly brought on by the prison environment which triggers distressing memories for women prisoners. These symptoms often include flashbacks and nightmares, which can be as severe as the acute symptoms experienced immediately following sexual assault. *Jane's* story is typical of the experiences of many women prisoners[107]:

When *Jane* was two years old her mother's de facto husband Wayne moved in to live with them. Almost immediately Wayne began sexually abusing Jane. It started as fondling and Wayne inserting his finger in Jane's vagina. As Jane approached puberty she was required to parade naked for Wayne and perform oral sex on him. By the time Jane was 11 years old, Wayne was regularly raping her.

Jane's behaviour was sullen, uncooperative and abusive. She repeatedly failed school assessments. When Jane went to high school she made friends with two girls who could get drugs from their brothers. Jane began to medicate herself to obliterate the knowledge of Wayne's abuse. She would use anything - alcohol, speed, cannabis, heroin …

Jane began stealing handbags from shopping trolleys, shoplifting, and small time supplying of speed to fund her own drug habit. On three occasions Jane was arrested and charged with multiple dishonesty offences. On the first occasion she was placed on probation for 18 months but received no drug counselling. On the second occasion, which was within the period of probation, she was sentenced to two years imprisonment wholly suspended. Again she received no drug counselling. On the third occasion, which constituted a breach of the suspended sentence, she was given a custodial sentence.

Her mother came to visit her soon after she was jailed. After the visit, *Desley*, a correctional officer told Jane to take her clothes off piece by piece and hand them to over. Desley told Jane to turn round slowly in front of her with her arms spread out. Desley told Jane to face her and lift her breasts with her hands. Jane was then told to turn round, stand with her legs apart, bend over and spread her buttocks apart with her hands. Desley told Jane to squat. Desley noticed the cord from Jane's tampon and told her to remove the tampon while she watched. Jane was told to cough.

Jane's heart was pounding. Her throat was dry. She felt she could not swallow, but there was a large lump in her throat which was choking her. She felt cold but her hands were sweaty. It seemed like she could not see properly. The world closed in. All she could see was Wayne demanding she "do her strip show" before he raped her. She wanted to throw up. She desperately needed a fix.

Desley told Jane that she will be strip-searched after every visit, even visits by her lawyer.

The experience of being confined and the lack of privacy, loss of control and loss of identity implicit in imprisonment, mimics the experience of sexual assault. Some common prison practices particularly contribute to re-traumatisation for many women. Strip searching is used frequently in Queensland women's prisons. Strip searching in itself constitutes sexual assault, and is a key re-traumatisation tool for many women prisoners[108]. Strip searching particularly impacts on Aboriginal women prisoners[109]. Women can be placed in administrative segregation. Here, they are kept in an enclosed space, often semi-clothed or naked, and under 24 hour surveillance. Where this surveillance involves male officers, women are at particular risk of re-traumatisation. On occasion, women are placed under these conditions for mental health reasons. Women with mental health issues are at extremely high risk of re-traumatisation. Women are particularly likely to be re-traumatised if they witness or experience sexual assault by male prison staff.

Ironically, prison also provides a *window of opportunity* to begin dealing with issues away from the pressures of everyday life. Women who may have been in denial are often forced to look at the impact of their sexual assault whilst in prison.

Since 1994, Sisters Inside has been providing a sexual assault counselling service in women's prisons in South East Queensland. In order to be referred to counselling by Queensland Corrective Services (QCS), women must disclose their sexual assault history to prison authorities to qualify for inclusion on the counselling list. This disclosure requirement is a major barrier to accessing help for many women. The fact that a large number of women are prepared to do this is an indication of the severity of their symptoms and the extent of further potential need amongst women prisoners. Over a 3 month period (January to

March 2010), indicatively almost 25% of women in prison in South East Queensland were referred to Sisters Inside for sexual assault counselling by QCS staff [110].

The capacity to address past sexual assault is critical to women prisoners. Few women received sexual assault services prior to imprisonment; for most, this is their first opportunity access support and work through issues related to their sexual assault. Many women prisoners have lived with multi-generational, entrenched family violence cycles. Family violence, including sexual violence, plays a key role in recidivism rates amongst criminalised women. Therapeutic intervention to address past sexual assault also functions as a crime prevention strategy. Ultimately, a woman will only build the resilience required to move forward with her life if she controls her personal information and the process of her counselling, support and recovery. This demands a *power with*, flexible approach to counselling women prisoners[111].

7.6 Emerging diverse needs

> *Our service recently had an 81 year old Indigenous woman disclose childhood sexual abuse perpetrated by her father. She came to the service after she provided a granddaughter with her diary in which the abuse was detailed. The granddaughter and her mother came for counselling, expressing how much they now understood about the level of violence and anger they had endured all their lives, and what a difference it made to know. The 81 year old woman disclosed that she needed to tell, after the death of her son (who was fathered by her father) who she hated all his life. As he was dying, following a lifetime of his own experiences of abuse, she realised the enormity of the generational impact. She stated that she would have liked to have told, 'but no one ever asked'.*
>
> (Sexual assault counsellor, Regional Service)

Sexual assault services are increasingly recognising the support needs of older women. Many women, now in their 60's, 70's and 80's, experienced sexual assault during an era when there were strong taboos around disclosure. They are only now disclosing the horrific experiences of 40 or more years ago.

Older women living independently are increasingly disclosing past and recent abuse. It may be that their son has taken over perpetration of sexual assault after his father dies. It may be that they have become concerned about the safety of their grandchildren. It may be that acknowledging their abuse is part of the end-of-life process of resolution and closure.

Women in aged care facilities are disclosing sexual assault. It may be that, for the first time, they are in a safe environment where they can afford to acknowledge past sexual violence. It may be that they have Alzheimers, and are reliving someone coming into their room at night. It may be that their abuse is recent - and perpetrated by male residents or carers.

With the ageing of the population, further disclosures amongst older women can be expected. More survivors of sexual violence will be living longer and a larger percentage of the population will be vulnerable to sexual violence. It will be important to explore the particular issues of older women who have experienced recent or historic sexual assault. Professionals in the aged care sector can be expected to require professional development to enable them to respond appropriately to disclosures of sexual assault.

7.7 The essential role of specific focus services

Each of the 5 current specific focus services is the custodian of a sophisticated, specialist body of knowledge about working with groups of women at the highest risk of sexual assault. Their staff have an intimate knowledge (and often personalised experience) of women in their particular target group. This expertise has been, and should continue to be, a rich resource for the sector as a whole.

The sexual assault sector relies heavily on specific focus services. Specific focus services collaborate widely with other specialist sexual assault services and provide sector support, resourcing and professional development activities. Specific focus services provide practical resources for women (including many thousands of pamphlets

annually) which are used widely by services to access and support disadvantaged groups of women. They provide professional training, education and support to professionals across the sector. They accept referrals from throughout the sector, particularly government services, and work with women whose high level of needs is outside the role or capacity of these services. Specific focus services engage with large numbers of women who are unwilling, or unable, to access other services - and would otherwise have received no support for their recent or past sexual assault. They provide the individual and systemic advocacy required to assist women to access mainstream services.

Specific focus services necessarily collaborate widely with other sectors, and contribute to their awareness of sexual violence and development of coordinated service delivery systems for disadvantaged women. Each of the specific focus services has built significant relationships with other service providers to their particular target group - the Indigenous sector, the multicultural sector, the youth sector, the disability sector and the criminal justice sector. Due to the complex needs of disadvantaged women, specific focus services also educate and support other professionals within the community services and health industries on a daily basis. This includes service providers in the housing, welfare, aged care, education, human rights and advocacy sectors. These collaborative activities play an important role in working toward the elimination of sexual violence.

Each of the specific focus services is funded by Queensland Health for the equivalent of 1-2 full time staff positions, based in Brisbane. Over many years, the 5 services have built credibility within their hard-to-reach target populations. As a result, the demand amongst disadvantaged women for direct service provision exceeds the capacity of all specific focus services. Additional resources are required to enable services to be located in, and/or have capacity to outreach to, other parts of Queensland where their population group is concentrated. Since many disadvantaged women have a high level of caution about using mainstream services, further funding for direct service provision would enable more women from specialist populations to access support following a sexual assault.

In regional, rural and remote areas in particular, many disadvantaged women will continue to rely on specialist sexual assault services. A number of rural service providers report having received invaluable advice, support and resources from specific focus services when working with these women. However, specific focus services are currently not adequately resourced to provide consistent statewide education, resources and support to other sexual assault service providers. Additional funds are required to improve access to pamphlets for women, written professional resources for workers, on-the-phone support and training opportunities on working with specialist populations of women.

Recommendation 16: That the Queensland Government recognise the expertise of existing specific focus services to provide a range of appropriate responses which meet the diverse needs of women who have been sexual assaulted.

Recommendation 17: That the Queensland Government increase funding to the 5 specialist sexual assault services to:

- Enhance their capacity to resource other services throughout the state to meet diverse service user needs.
- Enable them to respond to the identified increase in demand for services amongst women from specialist target groups.

8. Solutions - Health Promotion, Community Education & Prevention

This chapter focuses on strategies which aim to eliminate sexual violence. It identifies the importance of integrating prevention activities into direct service delivery with women who have been sexually assaulted. It articulates the multi-levelled, evidence-based, community education strategies required to change attitudes in the wider community. Training and professional development with services providers across the sexual assault sector, and more widely, also plays a critical role in moving toward a society free of sexual violence.

> *By learning different things from the other women and seeing how we fit in the big picture supported me in dealing with childhood abuse*. (Community education participant, BRISSC)
>
> *You know we're actually talking about cultural change. We're talking about changing something that is really engrained ... we need to do that in the context of ... how we construct gender identity.* (Interview participant cited in Carmody et al 2009)
>
> *It is time for action to … analyse the cost benefit of the current proportion of investment in crisis services and identify opportunities for reinvestment in prevention and early intervention.* (National Council to Reduce Violence Against Women and Their Children, 2009a, p7)

Non-government services currently provide a wide variety of community education activities, customised to the needs of their communities. These function at many levels - from integration of prevention and intervention with service users; to educating women's family and friends; to providing information about sexual assault and the services available to women; to targeted education in the wider community; to educating other service providers. Community-based services also provide a pathway for promoting and reinforcing public educational campaigns.

The proposed model would effectively silence sexual assault as a social and cultural issue, and treat it as an individual medical problem - even, a mental health issue requiring treatment. The proposed approach to counselling would preclude much of the integration of education and intervention which currently meets the needs of many women who have been sexually assaulted.

Community education and prevention activities are not included in the proposed model, and it is difficult to see how these activities would be possible within this approach. Government employees cannot speak out publicly about systemic barriers for women who have been sexually assaulted. Therefore staff would be severely limited in their ability to advocate for individual service users, produce media releases and facilitate community participation in wider anti-violence events. The proposed role of professional staff does not include building connections with the wider community. This would further reduce any capacity to provide prevention activities to address community-specific issues (e.g. respond quickly to address sexual assault incidents or unacceptable community attitudes toward sexual violence).

The KPMG report acknowledged the importance of a whole of government response to sexual violence; however it failed to recognise the need for a whole of community response. The proposed move toward a more forensic approach to service provision could be expected to effectively eliminate existing community education and prevention activities. Individualising sexual assault would invariably silence discussion of sexual violence and its causes. In practice, therefore, it would serve to condone sexual violence.

The most efficient and effective way forward is to build on the existing health promotion competencies in the sexual assault sector and:

- Support the implementation of best practice in community education and prevention.
- Enable existing services to extend their community education and prevention activities.
- Resource professional development activities across the sexual assault sector.

Continuing high rates of sexual assault demonstrate that social and cultural values which legitimise sexual violence continue to exist at all levels of Queensland society. A recent national survey found that 1 in 20 Australians continue to believe that *women who are raped often ask for it*[112]. In response to continuing high levels of violence against women, the Australian Government has committed an initial $42 million in the 2010-11 Budget - largely for primary prevention activities[113]. The Queensland Government should also place high priority on prevention of sexual violence:

Recommendation 18: That the Queensland Government recognise the central role of community education and prevention activities in reducing sexual violence, and adopt a whole of government policy to address community attitudes which legitimise sexual violence.

Non-government sexual assault services currently play the leading role in implementing a holistic approach to addressing sexual violence in Queensland. The broad range of activities undertaken by services reflects the 5 actions recommended in the *Ottawa Charter for Health Promotion* - contributing toward *building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills* and *reorienting health services.* A sexual assault service delivery system can only be both effective and efficient, if it includes sophisticated prevention and community education strategies based on a gendered analysis of sexual violence.

8.1 Relationship between intervention and prevention

Recognition of the inter-dependence of prevention and intervention is fundamental to efficiently achieving effective social outcomes. Best practice requires that prevention and intervention are highly integrated. Community education is essential to building community trust in services and functions as a form of intervention. Community education enables people to understand the wider social issues which need to be addressed in their community[114], if sexual violence is to be eliminated. Community-based sexual assault services hold unique knowledge of the needs of people who have been sexually assaulted within their geographic community or specific population group (their *community of interest*). Over many years non-government services have learned which prevention activities are most effective with their particular target population.

Community education for **women who have experienced sexual assault**

Prevention and intervention are interdependent. Community education for women who have experienced sexual assault is fundamental to effective service provision. Non-government services have developed sophisticated information, counselling, therapeutic and group work approaches which integrate an educational component into direct support work with women who have been sexually assaulted. Different strategies suit different communities. For example in small rural and remote communities where privacy is a central concern, group work is less popular than amongst some specialist populations.

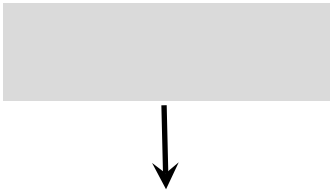
Community education for **non-offending family and friends**

Educating non-offending family members and friends can play a key role in women's recovery from sexual assault. A recent Queensland online study of over 500 people found that sexual assault impacted negatively on relationships with family and friends for almost 2/3 of respondents[115]. This suggests that the majority of women's potential supporters are ill-equipped, unable or unwilling to provide support. It further underlines the direct relationship between prevention and intervention, and plays an important role in non-government service provision.

Community education for **women in communities of interest**

Women are entitled to accurate information about sexual assault, and the support services available. Many women have been *educated* about their rights by the very men who are violent toward them - often a father or husband. Public perceptions of sexual assault are often narrow and couched in a frame of reference that legitimises

male power. Even women who understand their rights often don't know how to access support services. This is particularly true of disadvantaged women.



In short, prevention activities with women often lead to intervention, and vice versa. Concurrent provision of education and direct service provision optimises efficiency of service delivery.

Recommendation 19: That the Queensland Government continue to fund services which integrate community education and direct service provision.

8.2 Educating the community

Effective community education requires exposure of sexual violence and its causes. The long term goal to eliminate sexual violence in Queensland will be left largely unaddressed if campaigns do not address the gendered causes of sexual violence:

> *… in order to seriously work towards preventing violence against women, we need to apply socio-political understandings that address violence within the context of the state … As such, violence prevention initiatives need to be guided by a feminist framework. … in engaging men in men's violence prevention, we must name men's privilege, identify men's vested interests in and benefits from violence against women, move away from celebrating 'other' forms of masculinities, recognise resistance and backlash, and address the structural causes that underlie men's violence against women. Pease cautioned: 'If we're going to be serious about engaging with men, we've got to recognise that men have vested interests in not changing and if we do not acknowledge and recognise that and acknowledge the resistance, we're not going to bring about change'.*
>
> (Pease 2008 cited in Clark et al 2009, p 11)

It is essential that all community education is underpinned by analysis of the gendered nature of sexual violence. A research project conducted by the University of Western Sydney, commissioned by the National Association of Services Against Sexual Violence (NASASV) and funded by the Federal Office for the Status of Women[116], has developed a set of National Standards based on practitioner interviews and critical review of international and local literature on best practice in gender violence prevention education[117]. The first of the National Standards highlights the importance of using *coherent conceptual approaches* when designing community education:

> *The theoretical or conceptual approach used in a program provides the basis for understanding why sexual violence occurs and the prevention pathway that should be used to reduce sexual violence.*
> (Carmody et al 2009, p 2)

One of the 3 indicators of a quality program within this National Standard, is that the *theoretical approach will include an understanding of the gendered nature of society and the over representation of men among perpetrators of sexual violence*[118]. Other fundamentals of the framework include:

- That the goal of primary prevention is to achieve behaviour change.
- That primary prevention work must target men and women and include the broader community including strategies to engage parents/caregivers.
- That projects which are based on risk management and *stranger danger* are not primary prevention.
- That primary prevention programs target a range of delivery locations including schools.
- That primary prevention uses a range of practices to respond to geographical and cultural differences across Australia.

Recommendation 20: That the Queensland Government commit to best practice in community education and prevention through:

- Adopting the National Association of Services Against Sexual Violence (NASASV) *National Standards for the Primary Prevention of Sexual Assault through Education*.
- Requiring that all funded community education projects meet these National Standards.

Sexual assault workers are better equipped than generic professionals (such as teachers or trainers) to deliver this community education. By necessity, sexual assault workers have developed a sophisticated understanding of sexual violence, its causes, and its social and individual impact. Being able to talk from experience is an invaluable tool in community education. Workers can tell *real life* stories, and they have flanking knowledge which enables them to address questions outside the formal curriculum of a training program. Most importantly, they have the knowledge and skills to respond appropriately to participants who disclose a sexual assault and resource them to access services[119].

Community-based services are well placed to identify educational needs in particular communities and develop informed responses based on their understanding of social and cultural values within their community of interest:

- In smaller rural and remote communities, where service providers know many community members personally, community education can play a particularly direct and powerful role in reducing sexual assault. Staff are often aware of the specific locations or events where unacceptable attitudes are being promoted or a high incidence of sexual assault is occurring. In communities where police work closely with local services, service providers are often aware of police suspicions about patterns of sexual assault which fall outside the criminal code. Proactively addressing these needs can result in immediate reductions in the incidents of sexual assault within particular parts of a rural or remote community.
- Staff in specific focus services are aware of community-specific opportunities. Workers with refugee women are aware of opportunities such as English as a Second Language (ESL) programs, where women congregate in numbers. Workers with women with intellectual disability have long term relationships with Special Schools, and can use community education to reduce the risk of young women as they leave school.

Community education in rural or specialist communities goes beyond social marketing. The ability of organisations to influence social and cultural attitudes in their community continues to rely on their credibility and level of community engagement. Prevention activities will only be effective if the service is perceived as trustworthy and responsive to community needs.

Community education for **targeted community groups**

Non-government services frequently provide primary prevention activities directed at whole population groups - from schools, to churches, to vocational classes, to political parties, to parent groups, to sporting clubs, to marginalised social groups. Often, this training builds on existing violence prevention programs (such as respectful behaviours, anti-bullying or anti-homophobia training). Community based sexual assault services have particular expertise relevant to identifying population group targets and providing customised sexual assault training. This includes innovative strategies such as helping young people to develop *safety plans* in rural communities prior to major public events when a large opportunistic population is in town and a high incidence of sexual assault has occurred in the past.

Community education for **the general public**

Community education also focuses on building awareness more widely through campaigns such as *Enough is Enough* and *No means No*. Community-based services have the expertise to advise on such campaigns, and to implement and reinforce their messages at a local level. Community-based services can advise government on appropriate campaign messages, both for society at large and for particular communities of interest. Community-based services are able to make informed decisions about when, and how, to make use of wider social marketing campaigns, to ensure that they generate attitude change, rather than community resistance.

Community education **at a systemic level**

Community-based sexual assault services are aware of emerging patterns of need amongst service users, the limits of individual advocacy, systemic barriers and policy constraints on addressing sexual violence in society. As a result of both prevention and intervention activities, services have a sophisticated overview of many systems and their impact on victims/survivors of sexual assault. Community-based services play a key role in contributing evidence-based proposals to enable wider systemic improvements.

At present, most sexual assault health promotion, community education and prevention activities in Queensland are being provided by non-government services. All community-based services provide a wide variety of education and prevention activities. For example, over less than 2 years, a typical single rural service (Tablelands Sexual Assault Service) conducted a total of 41 events with almost 1,000 participants, in addition to contributing to wider community events through displays and informal interaction with the public. Similarly, a single young women's worker at CASV, provided 20 community education activities over a 12 month period in 2008/9, including:

- workshops, participation in major forums and information events, and display stands at public events,
- education to high school students, university students, Guidance Officers and senior teachers, other young people and members of minority communities,
- using a variety of methods including workshops, quizzes, joint art projects and presentations, and
- addressing a variety of flanking issues including healthy relationships, safe partying, the influence of drugs and alcohol and consent.

However, services are currently inadequately funded to provide the breadth of prevention activities needed in, and requested by, communities:

> *We were kind of doing it ... on top of our jobs, which is what's been happening with prevention across Australia and everywhere.*
>
> (Interview participant cited in *Framing Best Practice …*[120])

Community education should not be treated as an *optional extra*, to be undertaken in workers' *spare time*. A multi-faceted approach to community education is fundamental to eliminating sexual violence. Community-based services have the competencies required to provide high quality prevention activities, appropriate to the communities they serve. In particular, community-based services are aware of the critical gaps in community education in their communities of interest, which are contributing to perpetuating sexual violence.

Recommendation 21: That the Queensland Government enhance existing best practice in community education through:

- Articulation of prevention activities in service agreements.
- Increased funding to all community-based services, to enable them to address the diverse educational needs of communities across Queensland.

8.3 Training and professional development

The sexual assault service delivery system in Queensland currently draws together staff with a rich variety of competencies. Tertiary qualifications (in psychology, social work or human services more widely) is one possible way to secure some of the appropriate skills and resources required to work effectively in sexual assault services. Life experience, ability to function well in a group and commitment to working to reduce sexual violence are equally important to effective service provision. Sexual assault service provision is a specialist area, requiring high order competencies in specific areas:

> *As a social worker with 10 years experience across a number of fields of practice I know that I would have the soft skills required to work in the area of*

sexual assault services but would not presume for one moment that I had the specialist skills to be an effective counsellor without specialist training and supervision.

(Board Member, Sexual Assault Service, Central Queensland).

Professional staff are unlikely to access education specific to sexual assault through university training alone. The ability of professionals to deliver high quality work services largely relies on access to professional development opportunities. The KPMG report pays significant attention to the importance of adequate training for service providers. Given the far-reaching impacts of sexual assault, professional staff require specialist sexual-assault training in a variety of areas - including trauma, suicide, mental health, homelessness, drug and alcohol, eating issues and a variety of models of counselling. On-the-job professional development also occurs through the development and delivery of community education, contributing to developing a customised model of service suited to a particular community, professional supervision and networking with other sexual assault workers. Queensland needs regular, coherent, statewide training that draws on the expertise within the sector to resource sexual assault professionals and service providers more widely.

Professionals working with trauma on a daily basis require adequate support such as debriefing, mechanisms and internal/external supervision. Many sexual assault services structure staff positions with dual roles (commonly counselling and community education) in order to protect workers from burn out caused by constantly working with trauma:

> *Research has shown that having a more diverse caseload is associated with decreased vicarious trauma. A safe comfortable work environment is crucial for workers particularly for those working in settings that may expose them to violence. Social supports within the organisation are crucial and staff need to have opportunities to debrief and available supervision.* (Astbury 2006)

Community education at a professional level

Community-based sexual assault services currently provide extensive professional training. Whilst some provide some regular training, resource constraints mean that services are often restricted in their ability to provide professional development. Services report overwhelming demand to provide regular training which is sufficiently substantial to provide skills development[121] for school staff, hospitals/emergency departments, mental health services, corrections staff, police/detectives and non government organisations. Services also provide professional education through other means, such as publication of professional guides, hosting local conferences and individual professional support. They also train many volunteers and community-based workers, such as Lifeline counsellors and foster carers[122].

Non-government sexual assault services are widely recognised as key experts in specialist sexual assault service provision, with all services providing professional training and development within the sector and beyond. The vast majority provide services (at an undergraduate and post-graduate level) for universities and vocational training institutions. The vast majority provide professional in-service training for doctors, psychologists, nurses, midwives, teachers, lawyers, counsellors, detectives and many other professionals. Most have been asked to contribute to government professional development events, and almost half have been asked to contribute to national and/or international conferences. **Appendix 1** provides further details of the professional expertise of non-government sexual assault services, and **Appendix 2** lists a sample of major publications including peer-reviewed articles, conference papers, professional development guides, research papers, community resources and books.

Community education at a professional level plays a vital role in the prevention of sexual violence, and the development of responsive, competent services. The contribution of community-based sexual assault services to ongoing professional development must be continued and expanded into the future.

Recommendation 22: That the Queensland Government adequately fund existing services to produce resources and provide other professional development activities across the sexual assault sector. That this includes funding regular, coherent, statewide training that draws on the expertise within the sector to further develop sexual assault professionals and other service providers.

Recommendation 23: That the Queensland Government:

- Recognise the central role of cross-sectoral links in enhancing service provision for women who have been sexually assaulted.
- Support the maintenance and further development of links between the sexual assault sector and service providers in the medical, legal and other social systems.
- Resource collaboration within the sector to enhance medical, legal and psycho-social responses to sexual violence.

9. Solutions – A State Policy Framework

According to the National Council to Reduce Violence Against Women and their Children:

> *It is time for action to … Enhance the role of the community sector in preventing violence against women and their children through realistic and sustained funding for services and an investment in skilling and supporting the workforce to achieve holistic responses to the complex needs of women and their children who are victims of violence.*
>
> (The National Council to Reduce Violence Against Women and Their Children 2009b, p7)

This has been reinforced by the Australian Sex Discrimination Commissioner, through her recently released *2010 Gender Equality Blueprint*:

> *To reduce the incidence of violence against women and ensure women who experience violence have access to adequate support … services responding to the needs of women and girls who have experienced violence should be adequately funded as an urgent priority.* (Australian Human Rights Commission 2010, pp 25 - 26)

Whilst the Federal Government is making changes in policy to address the issue of violence against women, the Queensland State government remains devoid of policy direction, leadership and a statewide framework, to address sexual violence. None of the following key policy documents even mention sexual assault, sexual abuse, sexual violence or rape:

- *Towards Q2: Tomorrow's Queensland* (statewide long term targets to 2020).
- *Strategic Policy for Children and Families 2007-2011* (Department of Communities).
- T*he Office for Women Strategic Directions 2009-2010.*
- *The Queensland Health Strategic Plan 2007-2012*.

Further, the *Queensland Government Strategy to Reduce Domestic & Family Violence 2009 - 2014* does not mention the phrase *sexual violence* once, nor do its strategies reflect the undeniable gendered nature of sexual violence. This leaves Queensland without any clear direction in its response to this insidious issue.

In the absence of government leadership, services have developed their own collaborative, inclusive, woman-centred approach to service provision. Non-Government sexual assault services currently play the leading role in implementing, and continually improving, a holistic, rights-driven approach to promoting the health of individuals who have been sexually assaulted and the community as a whole, in Queensland.

The KPMG review of Queensland Health responses to adult victims of sexual assault correctly identified the Interagency Guidelines as the key document that should underpin service delivery. These Guidelines provide both overarching principles and an agreed framework which should inform all responses to people who have been sexually assaulted. Queensland sexual assault services agree that these Interagency Guidelines have not been well implemented and do not currently reflect the way in which services are delivered. Whilst Queensland Health played a lead role in co-ordinating the development of the Interagency Guidelines, there is no ongoing commitment to joint policy or practice improvements across the program areas. In the absence of support from Queensland Health to properly endorse and implement the Interagency Guidelines, aspects of the current service delivery system are inconsistent with these Guidelines.

There is currently no government policy that provides direction as to how Queensland as a whole should address sexual violence. It is essential that Queensland commit to addressing the epidemic of sexual assault across the state, and commit to working toward reducing and ultimately eliminating sexual violence. The Victorian Government has identified development of a collaborative approach, driven *from the ground up*, as its first Priority Action: *Establish partnerships across government and non-government agencies and accountable leadership structures for sustainable prevention*[123]. This provides a basis for the rest of the strategies outlined in the Victorian plan.

Queensland, too, requires a dedicated state framework to address sexual violence. The framework and its policies should reflect a commitment to a best practice public health response, including the 5 key actions outlined in

the *Ottawa Charter for Health Promotion* and agreed Australian best practice identified in the NASASV National Standards for service provision and community education.

Ultimately, the experts in how best to address sexual violence are those, mainly women, who have experienced sexual assault. Community-based sexual assault services use client-driven approaches to service delivery, and are therefore particularly attune to the ongoing and changing needs of women who have been sexually assaulted. This proposal has been driven by feedback from women who have been sexually assaulted about their needs and preferences. Sexual assault services encourage the Queensland Government to talk with service users to confirm these needs, and to draw on the expertise of service users themselves and non-government service providers, when developing this whole of government plan.

The multi-faceted, often compounded, needs of women who have experienced sexual assault cut across most state government portfolios. The entrenched social and cultural beliefs that reinforce and legitimise sexual violence are present throughout Queensland society. A whole of government commitment to addressing sexual violence would be reflected in whole of government financial contribution to ensure the establishment of a secure, adequately funded, sustainable suite of government and non-government services equipped to meet the rights and needs of survivors/victims of sexual assault and act decisively to address sexual violence throughout Queensland.

Recommendation 24: That the Queensland Government adopt a statewide framework, policies and a whole of government approach to sexual violence that is consistent with the national plan, and informed by the perceptions of women who have experienced sexual violence.

Recommendation 25: That the Queensland Government recognises that sexual violence is more than an acute medical crisis and considers funding augmentation across portfolios such as Health, Justice and Communities

10. Conclusion

> *The first door must be the right door for women and their children seeking support as a result of violence. The sector responsible for delivering services to women and their children shows great flexibility, adaptability and responsiveness. The sector's workforce, however, needs strengthening and strategic planning for the future so that services can attract and retain the right workers with the right skills. Services also need to be confident about sustained and adequate funding to support their delivery of high quality and tailored responses that meet the holistic, often complex and multi-dimensional physical, practical and emotional needs of victims and their families.*
>
> (National Council to Reduce Violence Against Women and Their Children 2009, p 9)

The Queensland sexual assault delivery system must be driven by a commitment to reduce, and ultimately eliminate, sexual violence in Queensland. This must be reflected in a coherent, whole of government strategy to address sexual violence and its consequences.

Best practice demands that the Queensland sexual assault delivery system be driven by the rights and needs of women who have been sexually assaulted. A flexible, responsive, articulated system requires a commitment to change and resourcing from all relevant government portfolios. The system must function in a collaborative manner which values a variety of evidence-based approaches to service delivery. Sexual assault services must be securely resourced to implement customised models of service which respond to the multi-faceted needs of their particular communities and individual service users. The system must respond to the need for specific focus services for populations which experience particularly high rates of sexual assault. The system must be able to address the needs of all women who have been sexually assaulted - both recently and in the past. In keeping with the Interagency Guidelines, all services must be encouraged to grow responsible, adaptable services that optimise opportunities and choices for women who have been sexually assaulted.

Best practice demands that the Queensland sexual assault delivery system recognise that women are overwhelmingly the group most affected by sexual violence. The system must ensure that a gendered analysis of sexual violence underpins all service delivery, including both intervention and prevention activities. The system must prioritise provision of services to women. It must recognise the value of women-only services, and the importance of addressing *women's business* and *men's business* through separate, proportionally-resourced services.

Best practice demands that the Queensland sexual assault delivery system is driven by internationally recognised public health principles. The system must acknowledge the central role of primary prevention and advocacy activities in addressing sexual violence. The system must recognise the capacity of community-based services to provide data about successful education and prevention strategies. It must value the contributions of sexual assault service providers to professional development across the sector, and resource regular, ongoing training and development opportunities for professionals working in the sector. It must value the unique contribution of specific focus services to provide statewide sector development, support and resources. The system must articulate, evaluate and further develop existing effective community education strategies, and provide the necessary resources to maintain and extend this work without any reduction in intervention services.

The Queensland Government has a unique opportunity to lead the way nationally, in developing an evidence-based sexual assault service delivery system driven by best practice. Women who have been sexually assaulted should feel that the Queensland Government is committed to supporting them to regain control of their lives. They should feel secure in the knowledge that they will be supported, in the ways they choose, until they have addressed the needs that have arisen from their sexual assault. All Queenslanders should have a sound understanding of sexual violence, and know that their Government has zero tolerance of sexual violence.

Glossary

Best practice	The practices (including model(s) of service and service delivery system) required to meet the rights and needs of people who have experienced sexual assault.
Community-based Service	A funded service which is community managed. Is used interchangeably with *non-government based services* throughout this paper.
Crisis needs	The word *acute* is a medical term. Its use implies that a victim's needs immediately following sexual assault are primarily medical. *Crisis needs* is used throughout this document in order to recognise the breadth of needs experienced by people who have been sexually assaulted - particularly their emotional and practical needs.
Model of service	An articulated set of values, principles, policies, aims, tools and techniques which guide or determine practice within a particular service.
Non-government service	Refer to 'Community-based Service' above.
Ongoing needs	This term is used in preference to *historical* sexual assault. It recognises the continuum of needs that are experienced by many people who have been sexually assaulted - recently or in the past. This includes the *acute* symptoms which may be experienced by service users at any time in their later life.
People who have experienced sexual assault	Wherever practical, this term (or *people who have been sexually assaulted*) is used throughout in preference to *victims* or *survivors*, which risks labelling service users. This recognises that a person's whole identity is not determined by the fact that they were sexually assaulted. Where this longer phrase is not practical, *victim* is used to describe people in the crisis period immediately following sexual assault, and *survivor* is used to describe anyone else who has experienced sexual assault.
Service users	In this paper, *service user* is only used to describe someone who has experienced sexual assault and is using a service. Other groups which could be conceivably described as *service users* (eg. participants in preventative programs or family/friends who are receiving support) are named explicitly in this paper.
Sexual assault, or *sexual violence*	*Sexual assault* and *sexual violence* are used interchangeably in this paper. Sexual violence is about power, not sex. For the purposes of this paper, *sexual assault* includes a range of behaviours beyond the narrow legal definitions in the criminal code. For example, people may experience the symptoms of sexual assault as a result of being emotionally coerced into participating in sexual activity or being forced to watch pornography. These people have the same need for justice and closure, as those who experience forms of sexual violence which are explicitly proscribed by law.
Specialist Sexual Assault Service	A service that is specifically focused on work with victim/survivors of sexual violence.
Specific Focus Sexual Assault Service	A sexual assault service that works with a specific population group which has a higher risk of experiencing sexual violence.
System design and management	The way a whole system (in this case, the Queensland-wide service delivery system) is designed and managed, to ensure that services collectively achieve an agreed purpose.

Appendices

Appendix 1
Findings on the Professionalism of Non-Government Sexual Assault Services

The following is a summary of the findings of a questionnaire conducted in conjunction with the writing of this paper. All 20 non-government services responded to the questionnaire - 19 completed the form; 1 sent emailed comments but did not tick the boxes. Accordingly, the statistics included here are over 19 services, except where the remaining organisation explicitly stated their involvement with particular activities during interview.

KPMG *best practice* criteria:

- 19/19 services have publicly available evidence of availability to victims of both recent and historical assault education activities.
- 19/19 services have publicly available evidence that services are provided in a timely way.
- 19/19 services have publicly available evidence of accessible and identifiable entry points.
- 18/19 services have publicly available evidence of governance arrangements which support integrated service delivery.
- 18/19 services have publicly available evidence of clear and unambiguous practice standards.
- 18/19 services have publicly available evidence of processes and procedures.
- 17/19 services have publicly available evidence of a victim-centred approach.
- 17/19 services have publicly available evidence of integrated services responses provided by competent professionals.
- 14/19 services have publicly available evidence of policy that focuses on prevention/ community education activities.

Contribution to professional/university education:

- 95% of services had been asked to take undergraduate students on placement (including social work, psychology, counselling and human services students).
- 74% had been asked to take post-graduate students on placement (including Master of Psychology, Master of Social Work, Master of Mental Health, Master of Psychotherapy and Master of Counselling students).
- 74% had been asked to contribute to undergraduate classes (including classes in social work, psychology, nursing, medicine, law and teaching).
- 37% had been asked to post-graduate classes (including social work, psychology, nursing, counselling and law).

Contribution to vocational education and training:

- 79% of services had been asked to contribute to community welfare-related courses.
- 68% had been asked to contribute to accredited certificate courses.
- 63% had been asked to contribute to police cadet training.

Contribution to in-service professional development:

- 79% of services had been asked to contribute to professional development activities for professionals (including doctors, psychologists, nurses, midwives, teachers, lawyers and counsellors).
- 74% had been asked to contribute to professional development activities for police (including detectives and DV Liaison Officers).
- 68% had been asked to contribute to Queensland Health staff training.
- 53% had been asked to contribute to a Queensland Health sponsored professional development event.
- 47% had been asked to speak or run workshops at a national sexual assault conference.

- 47% had been asked to speak or run workshops about sexual assault at another national conference.
- 21% had been invited to speak or run workshops at an international conference, including 10% at international conferences on sexual assault.
- 68% had been invited to contribute to other professional development activities (including training for multi-disciplinary local/state/commonwealth government staff teams, staff in other community-based organisations, private sector organisations and TAFE/university staff).

Referrals from government bodies:

- 100% of services had been asked to accept a referral from a Queensland government service.
- 100% had been asked to accept a referral from a Queensland Health service. (For one service, this accounted for 14% of their referrals. Referrals from mental health services are particularly common.)
- 100% had been asked to accept a referral from Queensland Police.
- 100% had been asked to accept a referral from Department of Child Protection.
- 84% had been asked to accept a referral from a Queensland Health sexual assault service. (The remaining 16% were located far from such a service. For one Brisbane-based service 7% of individual face-to-face counselling referrals over the past 3 years were from QH sexual assault services.)
- 84% had been asked to accept a referral from Department of Communities.
- 53% had been asked to accept a referral from the Education Department/schools. (For one service, 25% of referrals came from health professionals in schools.)
- Other key sources of referral within the Queensland Government included: Department of Housing, Queensland Corrective Services, Department of Justice & Attorney General, and Disability Services.
- Other government referral sources included: Centrelink, Department of Immigration & Citizenship, local government, Members of Parliament and university lecturers,

Referrals from fellow professionals:

- 95% of services had been asked to accept a referral from a doctor.
- 95% had been asked to accept a referral from a nurse.
- 89% had been asked to accept a referral from a social worker.
- 84% had been asked to accept a referral from a medical specialist (including psychiatrists).
- 84% had been asked to accept a referral from a psychologist
- 74% had been asked to accept a referral from a lawyer (including Office of the Director of Public Prosecutions).
- 63% had been asked to accept a referral from other professionals (including: counsellors, migration agents, youth workers, midwives, natural therapists, dentists, occupational therapists, imams, priests, child care workers, community leaders, court support workers, and many more).

Appendix 2
Sample of Major Non-Government Sexual Assault Service Publications

The following are a sample of the many resources produced by non-government sexual assault services in Queensland. They include: peer reviewed articles, conference papers, professional development guides, research papers, community resources and books.

Commentary on Models of Service

Prentice, Kathryn (2002), **A Report by Kathryn Prentice 2002 Churchill Fellow to Study Innovative Models of Childhood Sexual Abuse Primary, Secondary and Tertiary Prevention Programmes**, The Winston Churchill Memorial Trust of Australia, http://www.churchilltrust.com.au/fellows/detail/2140/

A study undertaken in the USA and UK by the Director of Phoenix House, Bundaberg, Qld.

Immigrant Women's Support Service (2001), **Exploring the Future of Non-Violence: Innovative practice models for responding to immigrant and refugee children and young people living with domestic and sexual violence**, author, Brisbane.

Ostapiej-Piatkowski, Beata & Anne, Stephanie (2009), *Multicultural identity and working across cultures in responding to violence* in **Newsletter of the Australian Domestic & Family Violence Clearinghouse**, Autumn 2009, Australian Domestic and Family Violence Clearinghouse, University of NSW, Sydney, pp 4-5.

Ostapiej-Piatkowski, Beata & McGuire, Christina (2008), *A critical reflection on feminist intervention in working with women from non-English speaking backgrounds who have experienced violence*, Immigrant Women's Support Service, Brisbane.

Paper delivered at the International Feminist Conference, Brisbane.

Zig Zag Young Women's Resource Centre (2006), **Lighting the Path: Reflections on counselling young women and sexual assault**, author, Camp Hill, Queensland.

This collection of essays includes work by a variety of workers from non-government sexual assault services. For a review of the book by Cameron Boyd, see: *Review: Lighting the Path. Reflections on counselling, young women and sexual assault*, in **ACSSA Newsletter,** No 1, 15 September 2007, pp 9-10, including:

> *Readers who are interested in this book might also like to follow up Zig Zag's other excellent publications* (p.10), and, *As a collection, the book convincingly frames sexual assault as a community and societal problem while also being practically useful for those assisting individual young women to heal from the violence they have experienced.* (p.10)

Specific Expertise of Non-Government Services - Practical Skills & Approaches

Allimant, Annabelle & Allimant Holas, Ana Maria (2004), *The social face of global violence – community development work with people from non-English speaking backgrounds surviving interpersonal and political violence*, Immigrant Women's Support Service, Brisbane.

Paper delivered at the Community Development Human Rights & the Grassroots Conference, 14-18 April 2004, Deakin University, Melbourne

Allimant, Annabelle; Wong, Eunice & Martinez, Beatriz (nd) *Changes and challenges in the therapeutic relationship when using an interpreter*, Immigrant Women's Support Service, Brisbane.

Brisbane Rape and Incest Survivors Support Centre (2006), **CRUISE: Creating resources for understanding issues of self-harm and empowerment,** 2nd Edition, author, Woolloongaba, Queensland.

This package includes a set of 12 postcards and booklet about self harm. The original resource was funded through a BCC grant; the 2nd edition was funded through a Zonta Club of Brisbane Inc. grant.

Botros, Helena (2009), *Trails of discovery (Equine Assisted Therapy Journal),* Phoenix House, Bundaberg, Queensland.

Centre Against Sexual Violence (2003c), **Sexual Assault: A booklet for professionals,** author, Logan, Queensland.

Centre Against Sexual Violence (2003d), **Sensitive, Sensible Support: A help and information guide for general practitioners,** author, Logan, Queensland.

Hegerty, Jane, ed. (2009), **Connecting the Threads: A resource for working with young women who have experienced sexual violence,** Zig Zag Young Women's Resource Centre Inc, Brisbane.

Immigrant Women's Support Service (2002), **Diversity Training Manual**, author, Brisbane.

Immigrant Women's Support Service (1998), **Protocols for Working with Women and Children who have Experienced Sexual Assault within the Context of Domestic Violence,** author, Brisbane.

Kilroy, Debbie (2006), *The Silent Scream of Sexual Assault: Counselling Women in Prison with a History of Sexual Assault*, in Zig Zag Young Women's Resource Centre (ed) **Lighting the Path: Reflections on counselling, young women & sexual assault,** Zig Zag, Brisbane.

Ostapiej-Piatkowski, Beata & Allimant, Annabelle (2008), **Working with Women of the Sudanese and Burundi Background: Practice reflections**, Immigrant Women's Support Service, Brisbane.

Signal, T., Taylor, N., & Prentice, K. (2009), *Animal Assisted Therapy: Improving the lives of child sexual abuse victims*, Department of Behavioural and Social Sciences, Central Queensland University, Rockhampton, Queensland.

Paper presented at Fourth National Conference, Australian College for Child and Family Protection Practitioners. A study of the utility and efficacy of a 10 week program developed and implemented by Phoenix House, Bundaberg, Qld.

Sisters Inside Inc. (2010), **Inclusive Support: A responsive alternative to case management**, author, South Brisbane.

This model of service is used across all Sisters Inside programs, including the Sexual Assault Counselling and Support Service.

Westerman, Joyce (2005), *It's Never Too Late: The counselling experiences of ageing female sexual assault survivors* in Underwood, Mair & Suridge, Kate (eds), *Abstracts and Proceedings of ERA 2005: The 4th National Conference for Emerging Researchers in Ageing: The Diversity of Ageing: Pooling the Evidence* (8 November 2005, Brisbane Convention and Exhibition Centre), Australasian Centre on Ageing, University of Queensland, pp 177 - 180.

Westerman, Joyce (2006), *Factors in positive counselling experiences for ageing female sexual assault survivors* in Shanley, Chris & Roberts, Teri (eds), *Abstracts and Proceedings of the 5th National Conference of Emerging Researchers in Ageing: Research Informing Positive Outcomes in Older Persons* (21 November 2006, Sydney Convention Centre, Darling Harbour), University of Sydney & University of Queensland, pp 187 - 190.

At the time of both of these publications Joyce Westerman was a part-time counsellor at the Gold Coast Centre Against Sexual Violence. Both were based on Joyce's research conducted as part of her PhD studies. *It's Never*

Too Late is derived from a project which aimed to reach out to older sexual assault survivors on the Gold Coast and attract older women to attend sexual assault counselling. The brochure and poster, using art work obtained through an art competition for older women, are available from Gold Coast CASV.

Community Education and Prevention

Brisbane Rape and Incest Crisis Centre (1996), **Understanding Incest: A booklet for women by women**, author, Highgate Hill, Queensland. (now BRISSC)

Brisbane Rape and Incest Survivors Support Centre (2002), **F.O.R Women: A booklet for women by women**, author, Brisbane.

Bundaberg Sexual Assault Service (1999) **A Guide for Women Survivors - Backpackers**, author, Bundaberg, Queensland. (now Phoenix House)

This booklet is available in several different languages.

Centre Against Sexual Violence (2003a) **Information for Young Women: A help and information guide for young women who may have been sexually abused,** author, Logan, Queensland.

Centre Against Sexual Violence (2003b), **About Sexual Assault: Information for adult survivors,** author, Logan, Queensland.

Gold Coast Centre Against Sexual Violence Inc. (2007), **Inspire Magazine,** Edition One, author, Southport, Queensland.

Gold Coast Centre Against Sexual Violence Inc. (2008), **Inspire Magazine,** Edition Two, author, Southport, Queensland.

See the Inspire website for excerpts from these magazines, which were largely written by Gold Coast staff at www.inspiremagazine.com.au. Edition 1 is sold out. Edition 2 is available for purchase at http://www.stopsexualviolence.com/?pageID=merchandise. Over 30,000 copies have been distributed. Edition 1 received two local Youth Achievement Awards, a Highly Commended in the 2008 Domestic and Family Violence Prevention Awards and was globally promoted by the Women's UN Report Program and Network after it was identified as an example of best practice in educating and supporting young women.

Holz, Katrina & Prentice, Kathy (2009), *Bumblebees Therapeutic Preschool Program: Quality practice example*, Phoenix House, Bundaberg, Queensland.

Paper presented at Fourth National Conference, Australian College for Child and Family Protection Practitioners.

Kilroy, Debbie & George, Amanda (2004), *Prisons: The perpetrators of violence and discrimination against women*, Sisters Inside, South Brisbane at http://www.sistersinside.com.au/reports.htm

Paper delivered at *Home Truths: Stop Sexual Assault and Domestic Violence - A National Challenge*, Conference of the Australian Centre for the Study of Sexual Assault, 15-17 September 2004, Sheraton Towers Southgate, Melbourne.

Kilroy, Debbie (2002), *Stop the state sexually assaulting women in prison: Strip searching*, Sisters Inside, South Brisbane at http://www.sistersinside.com.au/reports.htm.

Paper delivered at *Expanding Our Horizons: Understanding the Complexities of Violence Against Women*, Conference of the Australian Domestic and Family Violence Clearinghouse, 18 - 22 February 2002, University of NSW, Sydney.

Kilroy, Debbie (2002), *Stop the state sexually assaulting women in prison,* Women in Prison Journal, Vol 3, June.

Kilroy, Debbie (2001), *Strip searching women in prison*, Sisters Inside, West End, Queensland.

Paper presented at *Criminology in the Twenty-first Century: Public Good or Private Interest?,* 15th Annual Conference of the Australian New Zealand Society of Criminology, 21-23 February 2001, University of Melbourne, Melbourne.

Kilroy, Debbie (2000), *Women in prison & sexual assault,* Women in Prison Journal, Vol 1, October.

Macleod, Di; Stevenson, Justin; Walker Windmill, Natalie; Wilk, Kellie & Clarke, Mitchell (2007), **Stepping Through The Process (STEP) for Adult Rape/Sexual Assault Complainants Entering the Criminal Justice System and Their Advocates,** Gold Coast Centre Against Sexual Violence Inc., Southport, Queensland.

An information booklet is available at http://www.stopsexualviolence.com/?pageID=merchandise.

Reed, Jacqueline (2002a), **What is Domestic Violence? In English & Bosnian**, Immigrant Women's Support Service, Brisbane.

Reed, Jacqueline (2002b), **What is Domestic Violence? In English & Spanish**, Immigrant Women's Support Service, Brisbane.

Reed, Jacqueline (2002c), **What is Domestic Violence? In English & Vietnamese**, Immigrant Women's Support Service, Brisbane.

Reed, Jacqueline (2002d), **What is Domestic Violence? In English & Tagalog**, Immigrant Women's Support Service, Brisbane.

Wilk, Kellie; Macleod, Di & Poole, Narelle (2007), **SHE (Strength, Health and Empowerment) Young Women's Group Manual,** Gold Coast Centre Against Sexual Violence Inc., Southport, Queensland.

This 6 week program promotes healthy relationships with self and others for young women. Package includes a Group Facilitators Manual and CD ROM. Available for purchase at http://www.stopsexualviolence.com/?pageID=merchandise.

Women's House (1980), **Incest Survey 1980: Report of a phone-in survey conducted by Women's House Rape Crisis Centre**, Women's Community Aid Association (Qld) Ltd, West End, Queensland. (now BRISSC)

Service Delivery Gaps/Needs Analysis

Aldunate, Raquel (1999), *Issues for women of non-English speaking backgrounds*, Immigrant Women's Support Service, Brisbane.

Paper delivered at the Domestic Violence Court Assistance Conference, 18 March 1999, Magnetic Island, Queensland.

Aldunate, Raquel (1996), *Issue of service responses to victims (including child witnesses) and perpetrators of domestic violence in relation to people of non-English speaking backgrounds*, Immigrant Women's Support Service, Brisbane.

Paper delivered at the National Domestic Violence Forum, 23-24 September 1996, Parliament House, Canberra.

Allimant, Annabelle & Anne, Stephanie (2008), *No room…..homeless and the experience of women from non-English speaking backgrounds*, Immigrant Women's Support Service, Brisbane.

Paper delivered at the 5th National Homelessness Conference, 21-23 May 2008, Adelaide).

Gatbonton, M. Theresa (1992)**, *I Sometimes Want to Move Out…* : Abuse of young women of non-English speaking backgrounds**, Migrant Women's Emergency Support Service, Brisbane.

References

(The) Aboriginal and Torres Strait Islander Healing Foundation Development Team (2009), **Voices from the Campfires: Establishing the Aboriginal and Torres Strait Islander Healing Foundation** at: http://www.facs.gov.au/sa/indigenous/pubs/healing/voices_campfire/Pages/default.aspx

Aboriginal and Torres Strait Islander Social Justice Commissioner (2004) *Walking with the Women: Addressing the Needs of Indigenous Women Exiting Prison*, in **Social Justice Report 2004**, Human Rights & Equal Opportunity Commission, Canberra at http://www.hreoc.gov.au/social_justice/sjreport04/

Anti-Discrimination Commission Queensland (2006) **Women in Prison: A Report by the Anti-Discrimination Commission Queensland**, author, Brisbane, at http://www.adcq.Queensland.gov.au/pubs/WIP_report.pdf

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

Australian Bureau of Statistics (2010), **Recorded Crime - Victims, Australia, 2009**, Catalogue No: 4510, ABS, Canberra.

Australian Bureau of Statistics (2007) **Personal Safety, Australia, 2005**, reissue, Catalogue No: 4906.0

Australian Bureau of Statistics (2006), **General Census Data**, ABS, Canberra

Australian Bureau of Statistics (2004), **Sexual Assault in Australia – A Statistical Overview**, Catalogue No: 4523.0, ABS, Canberra at http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/C41F8B2864D42333CA256F070079CBD4/$File/45230_2004.pdf

Australian Bureau of Statistics (2003a), **Recorded Crime – Victims**, ABS, Canberra.

Australian Bureau of Statistics (2003b) **Disability, Ageing and Carers, Australia** (Catalogue No: 4430.0) at http://www.pcawa.org/wap3.php

Australian Bureau of Statistics (1996), **Women's Safety Australia** (Catalogue Number: 4128.0), ABS, Canberra

Australian Indigenous Health InfoNet (2005), *Summary of developments in Indigenous health promotion* at: http://healthinfonet.ecu.edu.au/health-systems/health-promotion/reviews/our-review

Australian Institute of Family Studies (nd) *Australian Centre for the Study of Sexual Assault - Statistical Information* at http://www.aifs.gov.au/acssa/statistics.html#safetysurvey

Australian Human Rights Commission (2010) **2010 Gender Equality Blueprint**, at http://www.hreoc.gov.au/sex_discrimination/publication/blueprint/index.html

Breckenridge, J. (1999) *Subjugation and silences: the role of the professions in silencing victims of sexual and domestic violence* in Breckenridge, J. & Laing, L. (eds) **Challenging Silence. Innovative responses to sexual and domestic violence.** Allen and Unwin.

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

Burstow, Bonnie (1992) **Radical Feminist Therapy: Working in the Context of Violence**, Sage Publications, UK.

Carmody, M.; Evans, S.; Krogh, C.; Flood, M.; Heenan, M.; & Ovenden, G. (2009) **Framing Best Practice: National Standards for the primary prevention of sexual assault through education** *(*National Sexual Assault Prevention Education Project for NASASV), University of Western Sydney, NSW. Summary at http://www.nasasv.org.au/PDFs/4_Page_Brochure.pdf

Clark, H., Duncanson, K. & Quadara, A. (2009) *Prevention Frameworks*, in **Aware** Australian Centre for Study of Sexual Assault Newsletter No 22.

Dean C.; Hardiman, A.; & Draper G. (1998) **National Standards of Practice for Services Against Sexual Assault**, Practice standards manual developed by National Association for Services Against Sexual Violence (NASASV), CASA House, Melbourne.

Doyle, B. (1996a) *Ignoring the Common Denominator – Sexual Abuse*, in **Parity** Issue 7 Vol 9 September 1996.

Doyle, B. (1996b) *Feminist services, mainstreaming and the question of men,* in **Women Against Violence: An Australian Feminist Journal**, November

Office of Women's Policy (2009a) *Fact Sheet No 2: State Plan to Prevent Violence against Women* June at www.ruralwomen.vic.gov.au/.../State+Prevention+Plan_Fact+Sheet+2/.../State+Prevention+Plan_Fact+Sheet+2.pdf

Office of Women's Policy (2009b) *Fact Sheet No 3: State Plan to Prevent Violence against Women - Outcomes of Consultation,* November at http://www.ruralwomen.vic.gov.au/web12/rwpgslib.nsf/GraphicFiles/State+Prevention+Plan_Fact+Sheet+3/$file/State+Prevention+Plan_Fact+Sheet+3.pdf

Office of Women's Policy (2009c) *Fact Sheet No 4: State Plan to Prevent Violence against Women - Prevention Across the Settings,* November at http://www.ruralwomen.vic.gov.au/web12/rwpgslib.nsf/GraphicFiles/State+Prevention+Plan_Fact+Sheet+4/$file/State+Prevention+Plan_Fact+Sheet+4.pdf

FAHCSIA - Department of Families, Housing, Community Services and Indigenous Affairs (2010) *Budget 2010-11 - Reducing violence against women - New Measures* at http://www.fahcsia.gov.au/about/publicationsarticles/corp/BudgetPAES/budget10_11/Documents/women/part_4.htm

Gilbert, J. (2006), *Cultural imperialism revisited: counselling and globalisation* in **International Journal of Critical Psychology**, Special Issue: Critical Psychology in Africa, 17.

Gilet, A. & Pane, S. (2008), *Real Connection, Real Action & Real Change: A Women's House approach to empowerment work with women survivors of sexual violence*, conference paper presented at "Let's get Savvy" Queensland Health Sexual Assault Conference.

Gowing, L.; Proudfoot, H.; Henry-Edwards, S.; & Teeson, M. (2001) **Evidence, Support and Treatment: The effectiveness of interventions for illicit drug use**, Australian National Council on Drugs.

Hockings, B.A., Young, M., Falconer, A. & O'Rourke, P.K. (2002), **Queensland Women Prisoners' Health Survey**, Department of Corrective Services, Brisbane.

Holden, T (2002), **Its still not my shame: Adult survivors of childhood sexual abuse report**, Women's Health Statewide, Women and Children's Hospital, Adelaide, at www.whs.sa.gov.au/pub/Its_not_my_shame_report.pdf, (Quoted in, ACCSA Wrap No.1 November 2005, Article: *Adult victims/survivors of childhood sexual assault*, Australian Institute of Family Studies)

International Violence Against Women Survey: The Australian component, summary at: http://www.aifs.gov.au/acssa/statistics.html#safetysurvey.

Jacobson, A. & Herald, C. (1990) *The Relevance of Childhood Sexual Abuse to Adult Psychiatric Impatient Care*, in **Hospital and Community Psychiatry** February 1990. Vol 41 No 2

Kilroy, Debbie (2004) **Submission of Sisters Inside to the Anti-Discrimination Commissioner for the Inquiry into the Discrimination on the Basis of Sex, Race and Disability Experienced by Women Prisoners in Queensland**, Sisters Inside, Brisbane, at http://www.sistersinside.com.au/media/adcqsubmission.pdf

Kilroy, Debbie (2002), *Stop the state sexually assaulting women in prison: Strip searching,* Sisters Inside, South Brisbane (Paper delivered at Expanding Our Horizons: Understanding the Complexities of Violence Against Women, Conference of the Australian Domestic and Family Violence Clearinghouse, 18 - 22 February 2002, University of NSW, Sydney) at http://www.sistersinside.com.au/reports.htm.

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

Leivore, D. (2003), Non-reporting and Hidden Recording of Sexual Assault: An International Literature Review, Office for the Status of Women, Canberra.

LivingWell's Initial Response to the KPMG Review of Queensland Health responses to adult victims of sexual assault in Spall Watters Group (2009) **Feedback Paper: Moving Forward Information Sessions**, Queensland Health, Brisbane.

Lucashenko, Melissa & Kilroy, Debbie (2005) **A Black Woman and a Prison Cell: Working with Murri Women in Queensland Prisons**, Sisters Inside, Brisbane at www.sistersinside.com.au/media/ablackwomenreport.pdf

Mental Health Branch, Department of Human Services (2006) **Building Partnerships between Mental Health, Family Violence and Sexual Assault Services**, State of Victoria, Melbourne.

National Association of Services Against Sexual Violence (2000), **National Data Collection Project: Report on the Snapshot Data Collection by Australian Services Against Sexual Violence,** CASA House, Royal Women's Hospital, Melbourne

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

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

National Council to Reduce Violence Against Women and Their Children (2009c), **The Cost of Violence Against Women and Their Children**, author, at http://www.fahcsia.gov.au/sa/women/pubs/violence/np_time_for_action/Pages/default.aspx

Pittaway, E. & Rees, S. (2005-6), *Multiple jeopardy: domestic violence and the notion of cumulative risk for women in refugee camps*, in **Women Against Violence: An Australian Feminist Journal** (18), p 19.

Pittaway, E. & Bartolomei, L.. (2005). *Refugee women at risk: Evaluating a UN program*, **Sydney Papers***, 17* (4 Winter - Spring)

Queensland Government (2009) **For Our Sons and Daughters: A Queensland Government Strategy to Reduce Domestic & Family Violence 2009 - 2014**, The State of Queensland at http://www.communityservices.qld.gov.au/violenceprevention/documents/strategy-to-reduce-violence.pdf

Queensland Police Service (2007), **Annual Statistical Review**, Statistical Services, Queensland Police Service, Queensland.

Quixley, Suzi (2010), **Improving sexual Assault Service Delivery in Queensland: Compilation of Questionnaire on the Expertise of Non-Government Sexual Assault Services in Queensland**, ESSQ Community Services Consultancy, Bowden, SA.

Rudd, Kevin (2009) Address to the National Council to Reduce Violence against Women and Children, Narrabundah College, Canberra, 29 April at http://pmrudd.archive.dpmc.gov.au/node/5203

Sisters Inside (2010), **Inclusive Support: A Responsive Alternative to Case Management**, author, Brisbane.

Springer, K.; Sheridan, J.; Kuo, D.; & Carnes, M. (2003). *J Gen Intern Med,* Volume 18.

Stanley, Janet (2003), *Child Sexual Abuse in Indigenous Communities*, paper presented a***t Child Sexual Abuse: Justice Response or Alternative Resolution Conference,*** Australian Institute of Criminology, Adelaide, 1-2 May at http://www.aic.gov.au/events/aic%20upcoming%20events/2003/abuse.aspx

State of Victoria (2009) **A Right to Respect – Victoria's Plan to Prevent Violence against Women 2010-2020,** Office of Women's Policy, Melbourne at http://www.women.vic.gov.au/web12/owpmain.nsf/headingpagesdisplay/family+violence

Stone, J. & Clifton, B. (2005) *Sexual Assault Resource Centre: Client mental health survey*, in **ACSSA Newsletter** No.9 November 2005.

VicHealth (2009a), **National Survey on Community Attitudes to Violence Against Women 2009: Changing cultures, changing attitudes – preventing violence against women,** author, Carlton South, Victoria

VicHealth (2009b), **National Survey on Community Attitudes to Violence Against Women 2009: Changing cultures, changing attitudes – preventing violence against women: Attitudes to Violence**, author, Carlton South, Victoria.

Victorian Health Promotion Foundation (2009) **National Survey on Community Attitude to Violence Against Women 2009:** *Changing cultures, changing attitudes – preventing violence against women - A summary of findings* at http://www.vichealth.vic.gov.au/Resource-Centre/Publications-and-Resources/Freedom-from-violence/National-Community-Attitudes-towards-Violence-Against-Women-Survey-2009.aspx.

Women's Health Matters: From Policy to Practice: 10 point plan for Victorian women's health 2005-2010 at http://www.wholewoman.org.au/publications/10%20point%20plan%20Dec%2005.doc

Women's Resource Centre (2007) **Why Women Only? The value and benefits of by women, for women, services**, London, UK at http://www.wrc.org.uk/includes/documents/cm_docs/2008/w/whywomenonly.pdf

Women Services Network (2000), **Domestic Violence in Regional Australia: A Literature Review**, a report for the Commonwealth Department of Transport and Regional Services cited in National Council to Reduce Violence Against Women and Their Children (2009c), **The Cost of Violence Against Women and Their Children**, author, at http://www.fahcsia.gov.au/sa/women/pubs/violence/np_time_for_action/Pages/default.aspx

Women's Resource Centre and Rape Crisis (England and Wales) (2008) **The Crisis in Rape Crisis: A Survey of Rape Crisis (England and Wales) Centres**, Women's Resource Centre, London, UK at http://www.wrc.org.uk/includes/documents/cm_docs/2008/t/the_crisis_in_rape_crisis_full_report.pdf

End Notes

[1] For the findings of this questionnaire see: Quixley 2010
[2] KPMG 2009, p1
[3] An ABS survey conducted in 1995 found that only 15% of women who identified an incident of sexual assault over the previous 12 months reported to police. Similarly,
[4] The Australian component of a major 2002/3 international study *(International Violence Against Women Survey: the Australian component*) involved phone interviews with 6,677 women, and found that:

- 1 in 7 women (14%) who experienced violence from an intimate partner reported the most recent incident to police.
- Just over 1 in 6 women (16%) who experienced violence from someone else reported the most recent incident to police.

[5] KPMG 2009, p1
[6] Australian Bureau of Statistics (2007) cited at Australian Institute of Family Studies (nd)
[7] Australian Bureau of Statistics (2007) cited at Australian Institute of Family Studies (nd)
[8] *International Violence Against Women Survey: the Australian component* cited at Australian Institute of Family Studies (nd)
[9] *International Violence Against Women Survey: the Australian component* cited at Australian Institute of Family Studies (nd)
[10] *International Violence Against Women Survey: the Australian component* cited at Australian Institute of Family Studies (nd)
[11] *International Violence Against Women Survey: the Australian component* cited at Australian Institute of Family Studies (nd)
[12] Dean et al 1998; Carmody et al 2009
[13] National Council to Reduce Violence Against Women & Children 2009a, p 12; State of Victoria 2009, p 4
[14] National Council to Reduce Violence Against Women & Children 2009a, p 24; State of Victoria 2009, pp 10, 23 - 24
[15] National Council to Reduce Violence Against Women & Children 2009a, p 24; State of Victoria 2009, pp 30 - 33; Office of Women's Policy 2009b, p 2
[16] National Council to Reduce Violence Against Women & Children 2009b, p 7; National Council to Reduce Violence Against Women & Children 2009a, p 24; State of Victoria 2009, p 19; Office of Women's Policy 2009a, p 1; Office of Women's Policy 2009b, p 2; Office of Women's Policy 2009c, p 1
[17] National Council to Reduce Violence Against Women & Children 2009b, p 5; State of Victoria 2009, p 19; Office of Women's Policy 2009a, pp 1, 2; Office of Women's Policy 2009b, p 2; Office of Women's Policy 2009c, p 1
[18] National Council to Reduce Violence Against Women & Children 2009b, p 5; State of Victoria 2009, p 19; Office of Women's Policy 2009b, p 2
[19] National Council to Reduce Violence Against Women & Children 2009b, pp 5, 7; State of Victoria 2009, pp 25, 30
[20] For example, 92% of reported rape victims are women and girls. State of Victoria 2009, p 9
[21] Najman et al 2005, cited in Astbury 2006
[22] de Visser et al 2003, cited in Astbury 2006
[23] Australian Bureau of Statistics 2003
[24] Queensland Police Service 2007
[25] National Council to Reduce Violence Against Women and Their Children 2009b, p 3
[26] For example: The Queensland Police found that of reported sexual crime in the 2006-7, 96% of perpetrators were men (Queensland Police Service 2007); the National Data Collection Project reported that in 96% of single-perpetrator sexual assaults, and in 89% of multiple-perpetrator assaults, the perpetrator was male (National Association of Services Against Sexual Violence 2000); according to an ABS study 99% of perpetrators of sexual assault over the preceding 12 months were men (Australian Bureau of Statistics 1996).
[27] State of Victoria 2009, p 13
[28] State of Victoria 2009, p 14
[29] National Council to Reduce Violence Against Women & Children 2009a
[30] State of Victoria 2009
[31] Queensland Government 2009, p 5
[32] Cited in Australian Bureau of Statistics 2004, p 45
[33] Women's Resource Centre 2007, p 64
[34] For example see: *Women's Health Matters* 2009; Women's Resource Centre 2007; Gilet & Pane 2008. Similarly, BRISSC 2008/9 service statistics identify that 65% of service users indicate a preference for women only services, whereas 0% indicated a preference for a mixed service.
[35] A major British study found through a random poll of 1,000 women:

- 97% stated that a woman should have the choice of accessing a women-only support service if they had been the victim of a sexual assault.

- 90% of women polled believed it was important to have the right to report sexual or domestic violence to a woman (such as a woman police officer).
- 87% thought it was important to be able to see a female health professional about sexual or reproductive health matters.
- 78% thought it was important to have the choice of a woman professional for counselling and personal support needs. (Women's Resource Centre 2007, pp 8 - 9)

[36] National Council to Reduce Violence Against Women and Their Children 2009c, p 4
[37] National Council to Reduce Violence Against Women and Their Children 2009c, p 8
[38] National Council to Reduce Violence Against Women and Their Children 2009b, p 4
[39] See for example: Jacobson & Herald 1990; Steiner-Craine et al cited in Doyle 1996a; Mental Health Branch 2006; Goodman 2001 cited in Keel 2005
[40] Mullen et al 1993 cited in Mental Health Branch 2006
[41] Human Rights Commission 1990 cited in Doyle 1996a
[42] See for example Brown 1993 cited in Doyle 1996a; Springer et al 2003
[43] Sisters Inside's data provided to Queensland Health 1994 – 2004
[44] Holden 2002, p 22
[45] Gowing et al 2001; Stone & Clifton 2004.
[46] KPMG 2009, p 4
[47] State of Victoria 2009
[48] Office of Women's Policy 2009a, p 1
[49] Office of Women's Policy 2009a, p 1
[50] Office of Women's Policy 2009a, p 2
[51] Office of Women's Policy 2009b, p 2
[52] Office of Women's Policy 2009c, p 1
[53] See for example, *The Universal Declaration of Human Rights*, which states:

- *Everyone has the right to life, liberty and security of person.* (Article 3)
- *No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.* (Article 5)

[54] See for example:

- *Convention on the Elimination of All Forms of Discrimination against Women* (Articles 3 and 4.1)
- *United Nations Declaration on the Elimination of All Forms of Racial Discrimination* (Article 2.3)
- *Convention on the Rights of Persons with Disabilities* (Articles 6.1 and 16.4)
- *United Nation Declaration of the Rights of Indigenous Peoples* (Articles 22, 23 & 24).

[55] National Council to Reduce Violence Against Women and Children 2009a.
[56] See for example a recent national survey which found that 1 in 20 Australians continue to believe that *women who are raped often ask for it*. Victorian Health Promotion Foundation 2009, p 8
[57] The ABS *Women's Safety Survey* in 1996 estimated that only 9% of women who had experienced sexual assault since the age of 15 years had seen a doctor (ABS 1996 cited in: Australian Bureau of Statistics 2004). The data are not specific about the setting in which the doctor was consulted. Hospital separations data, available from the Australian Institute of Health and Welfare (AIHW), record hospital separations of admitted patients whose admission is attributed to sexual assault as an external cause of injury. For the three years 1998-99 to 2000-01, the numbers of separations for female patients across Australia were steady at around 230 per year, with a small increase to 310 in 2001-02 (Cited in Australian Bureau of Statistics 2004).
[58] Anecdotal evidence suggests that very few women present for any form of service in the first 72 hours following sexual assault. Most are traumatised and do not begin to think about seeking professional help. Forthcoming information from a Queensland Health survey should quantify this. (Services have been told that Queensland Health plan to publish this data.) Between January and June 2009, Queensland Health asked non-government sexual assault services to identify the number of people they saw within the first 72 hours, within 2 weeks and after 2 weeks. Informal feedback from a number of services, based on data collected for the QH survey, suggests that they rarely see anyone in the first 72 hours, 20% - 30% of women seek help within 2 weeks of an assault, and 70% - 80% present more than 2 weeks following an assault.
[59] KPMG 2009, p 1
[60] BRISSC 2009
[61] National Council to Reduce Violence Against Women and Children 2009b, p 7
[62] Lievore 2005, p 67
[63] KPMG 2009, p 1
[64] Dean et al 1998
[65] **Appendix 1** provides further details of the referral sources of community-based sexual assault services.
[66] ABS 1996 cited in Australian Bureau of Statistics 2004
[67] Cited in National Council to Reduce Violence Against Women and Their Children 2009, p 70

[68] *LivingWell's Initial Response…* 2009, p 57
[69] National Council to Reduce Violence Against Women and Their Children 2009c, pp 70 - 72
[70] KPMG 2009, p 8
[71] See, for example, the *Bringing Them Home* Report, and Stanley 2003
[72] *International Violence Against Women Survey: The Australian component.* This may be an under-estimate of the frequency of sexual assault, since the data was collected via telephone interviews. Since this data was collected by telephone survey, participation was limited to women living in private residences with telephones. Therefore, it is reasonable to expect that Indigenous women (particularly those in rural or remote communities) were under-represented in the survey. However, the survey did capture the experiences of 92 Indigenous women.
[73] National Council to Reduce Violence Against Women and Their Children 2009b, p 7
[74] Specifically:

- *Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration. (Article 22.1)*
- *States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination. (Article 22.2)*
- *Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions. (Article 23)*
- *Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. (Article 24.1)*
- *Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.* (Article 24.2)

[75] National Council to Reduce Violence Against Women and Their Children 2009b, p 7
[76] Australian Indigenous Health InfoNet 2005, particularly Article 24.
[77] (The) Aboriginal and Torres Strait Islander Healing Foundation Development Team 2009, p 17
[78] CaLD - Culturally and Linguistically Diverse. CaLD communities may include people for whom English is their first language. IWSS currently focuses on service provision to NESB women, for whom English is their second language.
[79] KPMG 2009, p 8
[80] Pittaway & Rees 2005-6, p 19
[81] Pittaway & Bartolomei 2005, p 104
[82] National Council to Reduce Violence Against Women and Their Children (2009b), pp 3 - 4
[83] Victorian Health Promotion Foundation, 2009, #65, p 28; VicHealth 2009a; VicHealth 2009b.
[84] See particularly Article 2.3: *Special concrete measures shall be taken in appropriate circumstances in order to secure adequate development or protection of individuals belonging to certain racial groups with the object of ensuring the full enjoyment by such individuals of human rights and fundamental freedoms …*
[85] Leivore 2003
[86] Experiences such as inappropriate removal of their children by police or child protection authorities when women have reported family violence, further reinforces women's fears and reduces the likelihood that they will seek help in the future.
[87] Dimopoulos & Assafiri 2004 cited in National Council to Reduce Violence Against Women and Their Children 2009c, p 71
[88] Gilbert 2006, pp 10 - 28
[89] Based on:

- 10.5% of the female population of the wider Brisbane region are young women aged 12 – 15 (ABS 2006).
- 20% of the female population of the wider Brisbane region are aged 12 - 25 years (ABS 2006).
- 1 in 3 women report having unwanted sexual experiences in childhood (Najman et al 2005 cited in Astbury 2006)
- 1 in 5 adult women experience sexual coercion (de Visser et al 2003 cited in Astbury 2006).

[90] Australian Bureau of Statistics 2010
[91] Queensland Police Service 2007
[92] National Association of Services Against Sexual Violence 2000
[93] Australian Bureau of Statistics 1996
[94] National Council to Reduce Violence Against Women and Their Children 2009b, p 3 - 4
[95] Anti-Discrimination Commission Queensland 2006, p 33.
[96] Cited in Australian Bureau of Statistics 2003b. Similarly, the Peel Committee Against Woman Abuse in Canada has found that women with disabilities are estimated to be 1.5 to 10 times more likely to be abused than non-disabled women, at http://www.pcawa.org/wap3.php

[97] National Council to Reduce Violence Against Women and Their Children 2009b, pp 3 - 4
[98] Specifically, the Convention says:

- *States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms*. (Article 6.1)
- *States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.* (Article 16.4)

[99] Sisters Inside's data provided to Queensland Health 1994 – 2004.
[100] Hockings et al 2002, pp 52 - 54. This finding of a Queensland Department of Corrections survey is likely to be a conservative estimate because women in prison are very cautious about reporting their history of sexual abuse to people associated with corrective authorities.
[101] Women's House cited in Kilroy, Debbie 2004, pp 8, 26
[102] For example, Hockings et al 2002, pp 53 - 54 acknowledged similar findings on childhood abuse in NSW.
[103] ABS cited in Aboriginal and Torres Strait Islander Social Justice Commissioner 2004.
[104] Anti-Discrimination Commission Queensland 2006, p 32 - 33
[105] Anti-Discrimination Commission Queensland 2006
[106] Anti-Discrimination Commission Queensland 2006, p 116 - 118
[107] Kilroy, Debbie 2002
[108] Kilroy, Debbie 2002
[109] Lucashenko & Kilroy 2005
[110] There are generally 360 women in prison in South East Queensland. Most are in Brisbane Women's Correctional Centre (BWCC). Some are in the three low security facilities at Numinbah, Albion & Warwick. Between 1 January and 31 March 2010, QSC referred 65 women from BWCC, 14 women from Numinbah and 8 women in Albion for counselling. These 87 women indicatively comprise 24% of the prison population. (This can only be an indicative percentage, because the rate of prison turnover during this time is unknown.)
[111] For Sisters Inside's model of service see: Sisters Inside 2010
[112] Victorian Health Promotion Foundation 2009, p 8
[113] FAHCSIA 2010
[114] Such as sex role stereotyping, or sexual harassment. In her address to the National Press Club on 23 June 2010, Elizabeth Broderick, the Australian Sex Discrimination Commissioner, particularly noted the importance of addressing the continuum of behaviours that contribute toward violence against women.
[115] The BRISSC 2009 survey asked: *What impact did your experience/s of sexual violence have on your relationships with family and friends?* More than half the respondents to this question said it created conflict, almost 2/3 found that it led to isolation, and 25% decided to have no ongoing contact with their family/friends.
[116] Carmody et al 2009
[117] Carmody et al 2009, p 1
[118] Carmody et al 2009, p 2
[119] The National Standards state that *Programs need to identify how educators will be resourced with knowledge of sexual assault including a gender analysis, knowledge and skills to address survivors of sexual assault and how to access support services, and knowledge of prevention education theories and practices*. Carmody et al 2009 p 3
[120] Carmody et al 2009, p 4
[121] Services report a dearth of regular, on-going, in-depth sexual assault training for service providers in Queensland. Workers report having to travel interstate to access the *Certificate IV: Family & DV, Sexual Assault, Child Protection* - one of the few substantive specialist training offerings available.
[122] Quixley 2010
[123] State of Victoria 2009, p 30