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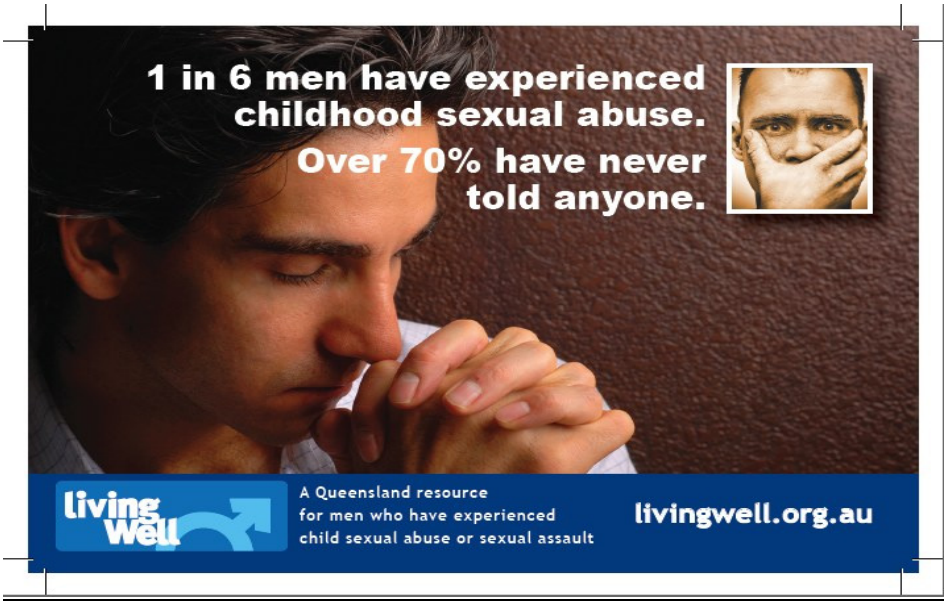

LivingWell's Initial Response to the KPMG Review of Queensland Health responses to adult victims of sexual assault.

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'There are some clear gaps in service delivery:

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

Introduction

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

Our position

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

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

Need to develop appropriate victim centred service responses

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

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

Fully integrated and coordinated service delivery throughout Queensland.

In seeking to develop a fully integrated victim centred response that ensures best practice in relation to the coordination of medical, forensic, police, counselling and support responses, the KPMG Review has proposed the implementation of sexual assault hubs within each Health Service District. Whilst it is clear that current best practice identifies a need for quality service provision that ensures synergy between forensic and medical responses, police/criminal justice systems and counselling/support, the hybrid 'co-located' model being proposed by the KPMG Review is only one possible hub model. In considering a way forward, it is important to note that the evidence that the KPMG Review calls upon to advocate the proposed 'one stop shop' is drawn from a review of the UK Sexual Assault Referral Centres (SARCs).[1]

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

- Hospital services for treatment of injuries
- GUM services for ongoing sexual health needs
- Victim Support, for information on police and court procedures, advice on claiming compensation and advocacy services where these are not available through the SARC
- Specialist rape crisis and other sexual violence organisations where clients:
  - have a preference for counselling/advocacy away from the centre;
  - have a preference for counselling in a women-only environment;
  - need long-term counselling; or
  - are victims of historical rather than recent sexual violence, including adult survivors of childhood sexual abuse."[2]

The SARCs model of service delivery clearly identifies best practice processes and protocols that can be drawn upon, and developed, to create an integrated and coordinated response to victims of recent sexual assault in Queensland. In advocating for the 'co-located' SARC style model there is however, a danger that 'co-located' becomes understood as the only possible representation of integrated and coordinated service delivery, when alternative models are available.

The Victorian model of service delivery is another model that prioritises the development of a fully integrated and coordinated response. The Centres Against Sexual Assault (CASA)

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

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

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

Although, within Victoria there is a history of services being provided within government departments, there appears no reason why victim centred services cannot be outsourced to lead community based agencies, with appropriate governance mechanisms in operation to ensure continuity of service provision throughout the state. In fact, the KPMG Review signals the value of lead community based agencies in responding to the needs of victims and survivors of sexual assault, in particular Indigenous people, and people from Culturally and Linguistically Diverse communities (2009:96).[3]


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


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

Gender

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

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

> *'importance of thinking about the role gender plays in the lives of sexual abuse survivors: it must not be conflated with sex and treated simply as a variable that may predict exposure to particular types of trauma or needs to be 'controlled for' in statistical analysis. It must be understood as a social construct that influences the way survivors make meaning of their experiences'.*[4]

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


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

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

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

> *'…post traumatic stress symptoms; depression; anxiety; dissociation; sleep problems; flashbacks; nightmares; anger; low self esteem; lack of confidence; self harming behaviours; suicide; alcohol and drug misuse; work-holism; prostitution; criminal activity (including – for a small minority – sexual offending) ; homelessness; revictimisation; parenting and relationship difficulties; eating issues; lack of trust; sexual difficulties; confusion of sexuality; chronic physical pain and mental health problems; transient psychotic episodes; borderline personality disorder; dissociative identity disorder and somatisation.*[5]

Research suggests that a need to create an environment where men's and women's experience are acknowledged in a way that neither ignores the influence of gender, nor amplifies its significance. As Hooper and Warwick note 'many of the experiences of retraumatization which adult survivor's encounter with services are the result of misrecognition of their experience or needs, and both denial of the relevance of gender and exaggeration (through reliance on stereotypes)".[6] [7] When gender is fore grounded as an influential factor requiring consideration, the specifities of women's, men's and transgender people's experiences of sexual assault becomes acknowledged and more appropriately responded to.

The Problem of under reporting and the barriers to accessing service

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

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

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

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

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

When designing a victim centred response to sexual assault there is a need, as the KPMG Review identifies, to address the significant issue of under reporting of sexual assault, and to design a service response that considers those many victims who do not wish to make a formal report to police. Research indicates that, even taking into consideration the extremely low rate of reporting of sexual offences by women, men are one and a half times less likely than women to report a sexual offence to police.[8] It appears that:

- Between 70-90% of men who have experienced child sexual abuse haven't told anyone.
- In one study of 40 boys who experienced child sexual abuse and attended an adolescent medical facility, none had ever told their primary care giver.
- Men typically disclose childhood sexual abuse or sexual assault 10 years later than women.[9]

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

Disclosure at the time	Men n=122	Women n=151
Disclosed	26.2%	63.8%
No disclosure	73.8%	36.4%
Time taken to discuss	Men n=145	Women n=138
Less than 1 yr	9.7%	14.5%
Less than 10 years	17.2%	36.2%
Less than 20 years	28.3%	23.9%
More than 20 years	44.9%	25.4%[10]

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

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

Queensland Police Service – Reported Sexual Offences 2008/9

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

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

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

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

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

In 2006 the Queensland population of males was recorded at 1,935,400 (413,900 under 15 and 1,521,500 over 15). The 2005 Personal Safety Survey was the first of its kind to ask questions about sexual assault of males, previously questions in relation to sexual assault had only been asked of women through the 'Women's Safety Survey'. The Personal Safety Survey identified that 0.6% of men experienced sexual assault in the year prior, 4.5% reported being sexually assaulted before the age of 15, and 5.5% reported being sexually assaulted at age 15 and over.[11] This translates to:

Personal Safety Survey 2005

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

In presenting these figures it is recognised that some Queensland men will experience sexual assault as both a child and as an adult. However, international research over the past 20 years has consistently produced figures that suggests 1 in 6 males experience childhood sexual abuse or sexual assault.[12] In the Queensland context the KPMG noted that this is equivalent to:

KPMG Review 2009:37

- 362,400 Queensland Men who have experienced childhood sexual abuse or sexual assault.

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


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

In the 2008 'Cry for Help' report into 'client and worker experiences of disclosure and help seeking regarding child sexual abuse', a specific recommendation was made to 'Build the confidence and skills of 'victims' to disclose CSA and seek help, by circulating stories of other survivors (that are tailored to a range of age groups) through, for example, radio, theatre, publications, beer coasters. Given the high incidence of unhelpful responses to disclosures, these stories may include advice on what to do if a disclosure is not met with the response that was hoped or expected.[13]

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

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

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


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

Barriers to disclosure and accessing services

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

In seeking to respond appropriately to men who have experienced sexual assault, the KPMG review highlights the need to address particular issues and barriers to accessing support and services. Whilst typically, men experience many of the same challenges that women experience in seeking to speak about sexual assault and to access appropriate support, it is recognised that men identify struggles with restrictive gender stereotypes, homophobia, victim to perpetrator discourse and lack of developed services (KPMG 2009:37).

Dominant Masculinity

Dominant stereotypes of masculinity that suggest that boys and men should be strong and able to defend themselves, even against overwhelming odds, make it difficult for men to talk about sexual abuse or assault. O'Leary notes that 'dissonance between male role expectation and the experience of 'victimisation' impacts significantly on men's experiences and can have men questioning their whole gender identity.[14] Men who have been sexually assaulted report difficulties with limited stereotypical ideals of manhood that portrays men as:

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

Limited ideals of manhood can compound problems for men, in that men are often down on themselves for not stopping the assault from happening and for struggling with the aftermath, because 'as men they should be able to cope'. This sense of 'failure as a man' make it less likely for men to speak about the sexual assault and seek help, leading to increased isolation and its accompanying problems.[15]

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

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

Homophobia

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

Although the KPMG Review identified that '[b]eing a victim of sexual assault can be a challenge to common masculine stereotypes of men being able to protect themselves, and this can create difficulties for males expressing weakness or vulnerability and seeking support', and that 'particularly relevant to males are sexual orientation conflict, homophobia, male specific sexual dysfunction and compulsion'(KPMG 2009:37). It is unclear how these barriers to reporting and accessing services are to be addressed?

Victim to perpetrator discourse

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

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

Although, it is important to intervene where abuse is occurring it is also important to be aware that research has found that 'most male victims of child sexual abuse do not become paedophiles, but particular experiences and patterns of childhood behaviour additional to sexual abuse are associated with an increased risk of victims becoming abusers in later life'.[16]

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

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

Lack of services to men as a barrier to gaining assistance

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

The KPMG review highlights that the current lack of visible support for men who have experienced sexual abuse or sexual assault, not only stops men from speaking about what was done, but can actually compound problems. This issue is particularly pertinent in designing a way forward for Queensland Health given non-government sexual assault service funding is currently directed to provide women only services. [17] [18] Adding to the difficulties is the fact that in the sexual assault field, it is an unfortunate reality that 'compared with females, recognition of male victims is seen as a relatively new discovery, and attitudes to service delivery needs and other responses can be uninformed and indifferent'.[19]

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

There is a challenge for Queensland Health in transitioning from a service delivery model designed specifically to address men's violence against women, to a model designed to assist all victims and survivors of sexual assault. Given that current service models have been developed and enhanced in relation to working with women, it may be necessary to devote some dedicated thinking and resources to designing appropriate service models for working with men. When Victorian CASAs commenced provision of services to male clients additional funding was provided to assist with the transition.[20]

Practice standards

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

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

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

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

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

address some unique issues faced by male victims and the implications for practice" (NSPM, 1998:vii).

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

Victim choice, as to the gender of the practitioner

The KPMG Review advocates a 'victim centred' approach that emphasises 'victims should be able to control the pace of all interventions and make informed decisions about the response should occur" and that "this includes having choice about the sex of the medical examiner" (KPMG 2009:3). It goes on to quote research that found 74.6% of all victims attending an acute medical forensic service indicated a preference for a female counsellor/support worker, and that 'some men feel safer working with women, especially in the context of emotional repression and relationship struggles. Alternatively others need the opportunity to explore issues of sexuality, masculinity/vulnerability and social behaviour with men'.[21] Whilst it is acknowledged that 'preferences are not always predictable, and other factors such as worker's personality, personal experience of abuse, ethnicity or status as a parent may be more important to some people than gender'. It is also recognised that opportunities to choose the providers gender can assist in the 'reparative' process and should be part of any best practice response.[22] Currently, SAMSSA and a number of Victorian Centres Against Sexual Assault operate a best practice model of offering service users choice as to whether they wish to see a male or female counsellor.[23]

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

Emphasis on men friendly services

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

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

The National Men's Health Policy Information Paper notes that "The existence of services does not mean that they are being used well, or by those who can substantially benefit" and it recognises that men visit health care professional less than women, and seek help

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

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

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

only after a crisis has occurred.[24] The men's health strategy paper highlights the needs for community responses that engage and reach out to men and produce cultural change in men's help seeking. Men who have experienced childhood sexual abuse, like many men, are often not accessing health service until their health has become severely compromised. For example, one man described how:

> *'It was last August when it just went bang! I had sort of handled things up to that stage. I thought things would never change. I must have fucked it up bad. Lost my licence ... because I got pissed and stoned all the time and did whatever I wanted to do ... I went with this chick ... we'd been in the sack together and I had visions of when I was a kid - went back there and it freaked me out. It was after that I got pissed. I was popping Valium two at the time, and ran amuck. Went home on a Saturday and didn't wake up til Monday! My old lady [mum] found me on the floor, and I ended up in hospital for a couple of days. That's when I thought I'd better sort out this shit once and for all.'*[25]

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

> *'To be fair, men don't disclose as frequently or as easily as women do…so they [health professionals] aren't going to ask the question. They aren't going to hurt the man's feelings by saying well have you been abused…But I think they need to be better aware of the signs especially in men and to, if necessary, ask the questions".*[26]

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

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

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

Eight principles for working effectively with men

1. The importance of perceived equality

A gender equity approach recognises that gender is a social determinant of health, and that men and women are given equal opportunity to maintain and enhance their health (WHO,2001 'Madrid Statement'). A gender equity approach recognises the different

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

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

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

challenges that face men and women in managing their health, including their different health requirements and the different barriers they face in accessing services. Learning from the men and family relationship programs recognises that:

- When a man makes an initial contact with a program, the immediate environment and openness of staff towards him, will influence his level of engagement and trust. Most men enter new situations with suspicion about what will be expected of them and they rely on visual cues that suggest they can relax.[27]
- If there is a perceived power difference between men and the service providers, men will be more cautious and wary of engagement.
- Many organisations have found it useful to display positive posters. These posters are rich in Australian images of 'perceived equality' or close connection with important relationships, promote hope, health and well being.

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

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

The Working with Men Guide suggests that:

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

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

- Not being well informed about what counselling involved.
- Believing that counselling does not 'work'.
- Feeling that existing services are really for women.
- Feeling uncomfortable with the language and modes of communication traditionally used in counselling.

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

Experience in developing men and family relationship services suggests that:

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

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


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

4. The value of personal recommendation about services

It appears that:

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

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

5. The importance of flexible service delivery

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

- Individual and couple counselling,
- Counselling outside working hours.
- Evening programs.
- Support groups.

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

6. Client involvement in program development

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

7. The solution focussed approach

Evidence from the Working with Men Guide is that:

- Men prefer a solution focussed activities and framework, and in particular adoption of a non-deficit approach. It is suggested that the solution focussed approach works well because it uses active solutions to current problems and involves practical tools.[28]

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

> *"Although there is little doubt that men and women undergo many of the same traumatic events and suffer in many of the same ways, it is clear that (1) some traumas are more common in one sex than the other, and (2) sex role socialisation affects how such injuries are experienced and expressed. These differences, in turn have significant impact on the content and process of trauma-focussed therapy."*[29]

The KPMG Review noted that 'Work undertaken by the Institute of Family Studies has identified two treatment types that predominate in the literature', those being 'Cognitive therapies that seek to alter distorted cognitions' and 'Feminist group therapy approaches'. A difficulty in relying on this referred to report (Jill Astbury's article 'Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia'), is that its focus was on service responses to women. Although research suggests that cognitive therapies can help, the difficulty is that few approaches have been subjected to extensive or long-term evaluation with male survivors of sexual abuse. [30]

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

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

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

8. Local area coordination

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

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


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


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

Designing a response to meet the diverse groups of men

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

> *'As services have developed and evolved, it has been increasingly recognised that not all victim sub-groups have been able to access sexual assault programs and services to the same extent. The needs of male victims, children, victims from indigenous and other culturally and linguistically diverse backgrounds, those from rural and remote communities and adults who have suffered historical abuse, have all become the focus of more dedicated thinking. Service providers should be aware of and plan around the barriers to accessing services that some groups of clients may experience.'(KPMG,2009:36)*

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

> *Epidemiological findings consistently reveal that the overall disease burden on men is not spread across all sectors of society, but rather disproportionately falls on some sections of the men's population. The use of aggregated data and averaging often conceals the fact that it is some groups of men who bear the heaviest burden of poor health.*[31]

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

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

Indigenous victims

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

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

The recent *Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred"* Report both emphasised the serious problem of sexual abuse within the Indigenous community and compounded problems for Indigenous men in further stigmatising them as potential perpetrators of abuse. In responding to Indigenous men who have experienced childhood sexual abuse or sexual assault it is important to recognise the Indigenous men's over representation in relation to poor health outcomes, including risk of suicide, drink and drug abuse. The 'Promoting Good Practice in Suicide Prevention: Activities Targeting Men' highlights the fact that young Aboriginal and Torres Strait Islander males are more likely than any other young Australians to die by suicide and that suicide rates are 40% higher in Indigenous communities than the Australian population as a whole.[32] The report suggests specific strategies be developed to work with Indigenous men.

The National Health and Medical Research Council in its "Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder' acknowledges that a challenge in designing appropriate service responses is that there is very little evidenced based research to inform practice (there have been no trials to date to investigate efficacy of any treatments of PTSD in Indigenous people). The Guidelines emphasize that the magnitude of the problem of trauma in the Indigenous community is potentially overwhelming for individual practitioners and services. It identifies a need for a commitment to long term therapeutic work in collaboration with Aboriginal and Torres Strait Islander people, considering age, seniority and gender in determining who provides treatment to whom and under what circumstances. In responding to Indigenous people the 'Guidelines' identify a need to attend to people's current life circumstances and to ensure there is appropriate support and supervision of practitioners. [33]

Research indicates that effective engagement with Indigenous clients involves valuing and linking in with the expertise of Indigenous people. Aboriginal Elder Ray McMinn interviewed for the Working with Men and Family Relationships Guide (2009) states that interventions need to involve both elders and young males, to work alongside culturally competent staff in developing and maintaining services that are culturally appropriate.[34]

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

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

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

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

Victims from culturally and linguistically diverse backgrounds

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

The report highlights the additional cultural and linguistic barriers to people from CALD backgrounds accessing services. Currently Queensland Health funds a sexual assault specific program through the Immigrant Women's Support Service providing referral and assistance to women and children. Although Crome (2006) discusses how established agencies might re-design service delivery to include men from CALD backgrounds as a type of "value added extra" service, it is generally accepted that men from Non English Speaking Backgrounds would have great difficulty in disclosing sexual assault to services that are specifically designed for women, or may appear to be ambiguous about receiving men as clients.[35] The challenges in responding appropriately is not just in relation to encouraging disclosure but in designing a suitable 'victim centred' response. Difficulties can exist not only in relation to disclosure. Grossman, Sorsoli, and Kia-Keating (2006) research suggests that men's experiences and meaning making as victims of childhood sexual abuse or assault were influenced by ethnicity and that men of colour are less likely to access trauma focused therapy.[36]

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

- Sexual assault occurring as an aspect of deliberate torture, accompanied by the witnessing of beatings and or the death of family and community members.
- Lengthy immigration experiences often over several years duration, and involving lengthy periods of temporary detention
- Disruption to family relationships eg loss of the support of parents, children, community
- Changing dynamics of authority and power between generations and opportunities for support
- Disappointment of expectations, lack of recognition of education qualifications and work experience
- Sense of loss of connection, loss of identity.
- Isolation, depression, loss of hope
- racism. [37]

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

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

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

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

Gay, lesbian, bisexual and transgender people

In articulating 'Best Practice Elements of Contemporary Responses' The KPMG Review included lesbian, gay, bi-sexual and transgender people as amongst those who experienced greater barriers in accessing services. In so doing, the review identified 2.5% - 4% of gay men and lesbians and 10-11.5% of transgender people in Australia having been sexually assaulted or raped, however, it is relevant to note that national and international studies suggest much higher prevalence rates. In the Australian *Private Lives* survey 19.6% of gay identifying men reported being forced to have sex by their partner. The New Zealand study '*Sexual coercion amongst gay men*', identified 11 International studies completed over the past 15 years that reported rates of sexual coercion amongst men who have sex with men ranging from 20.3% to 51%. [38]

The fact is that gay men, bisexual men, transgender men and men who have sex with men report significantly higher rates of sexual assault both as children and adults than the straight male population. For gay and bisexual men, as well as men who have sex with men, institutional heterosexism becomes a barrier that will often inhibit reporting of all except the most extreme cases of sexual assault.[39] Those who do report assaults may, if possible, conceal their sexuality.[40] Gay and bisexual men also report difficulties in disclosing their experiences of sexual coercion and assault to friends and family. For some, disclosing may necessitate 'coming out'. In some instances remaining silent and dealing with the accompanying difficulties may be preferable to the identity and relational implications of 'coming out'.[41]

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

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

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

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

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

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

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

> *The marginalisation of gay men in a heterosexist society contributes to the silence around men's experiences of sexual coercion in more ways than one. Gay men are already frequently labelled as 'predatory' and …that bringing to light stories of gay men being coerced into sex by other gay men risks confirming this stereotype. For a community that is already marginalised, this is potentially problematic. We are very mindful of the delicate political balance that is faced in raising issues such as this — discussing such aspects of a community whose members remain oppressed and disadvantaged to varying degrees within western societies opens up the risk of further discrimination.*
>
> *However, many of the forms of sexual coercion discussed in this report are acts that may be experienced as violating, distressing, and traumatic, in various ways, for the men involved. They can also be experiences that threaten a man's ability to avoid unsafe sexual practices. It is therefore important that space be opened within (and beyond) gay communities for acknowledgement, and candid discussion, of the issue of sexual coercion among gay, bisexual, and other men who have sex with men.*

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


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

Rural and remote victims;

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


It is unclear from the review how, the gender specific needs of women and men who have experienced sexual violence and who live in rural and remote Queensland, will be addressed in a coordinated way? It will require some dedicated creative thinking and funding support if sexual assault is not to become an experience that increases

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

disadvantage between men and women residing in metropolitan Queensland and men and women living in rural and remote Queensland.

Males with a Disability

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

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

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

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

- Disabled people have many more dependent, long-term personal relationships especially if they live in an institutional setting. Because of their increased exposure to potential abuse in various care settings and their dependence on others, disabled people are at far greater risk and are far more likely to be assaulted than non-disabled people by persons that they know.
- Disabled people are also vulnerable to threats and abuse that is specific to their disability e.g. the use of restraints, medication, reduced hygiene care, food or mobility. Sexual abuse often occurs when sexual activity is demanded in return for assistance. These types of coercive and punitive strategies are rarely recognized by others as occurring within a violent context.
- Similarly it can be extremely difficult for disabled people to report these strategies as abusive and non-consensual when they may appear to be "going along with it". And it can be even more difficult to prosecute a case when the person committing the abuse is not someone who is intellectually disabled and claims that consent was given. This has strong implications for acute sexual assault services in understanding the nature of the assault following a presentation, the issue of consent to forensic, medical and legal services which may follow, and the relationship of any support persons in attendance.[43]

 While there are some sexual assault specific services such as WWILD that already provide counselling support to women with disabilities who have been subjected to sexual

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

assault, it is unclear from the KPMG Review how the specific needs of men who have disabilities will be recognized and appropriately responded to throughout Queensland?

Males with a Mental illness

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

- 17.2% of community men qualify for a clinical diagnosis compared to *65.8% of men who were sexually abused as children.*
- Men who were sexually abused as children were 10 times more likely to qualify for a diagnosis of PTSD (post-traumatic stress disorder).
- Men who were sexually abused as children were 5 times more likely to engage in alcohol and drug abuse
- Men who were sexually abused as children were 10 times more likely to report suicidal ideation
- 46% of CSA men had attempted suicide at sometime.[44]

The 'cost' in health outcomes of sexual assault of men highlights a need to be pro-active in developing relevant service responses for men that intersect with mental health services. A targeted service response will be able to build upon recent research that identified the greatest predictors of male victims of sexual assault engaging in suicidal ideation are 'feeling isolated and alone, acting violently and aggressively, blaming themselves for the abuse occurring, feeling fearful, anxious or confused and usage of alcohol and drugs'.[45] When it is considered that between 1994 and 2004 men accounted for 80% of the deaths by suicide in Australia and that men who have experienced childhood sexual abuse report such a high level of suicide attempts it is problematic that the excellent document 'Promoting Good Practice in Suicide Prevention: Activities Targeting Men' Life is for Everyone Publication 2008 does not have a section detailing how best to respond to men who have been subjected to sexual violence. In developing a response to men who experience mental illness it may also be possible to learn from the Victorian Government Document 'Building partnerships between mental health, family violence and sexual assault services' which, although women centred, highlighted a need for integrated and co-ordinated service response across government departments.[46]

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

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

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

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

Male victims in institutional settings

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

The most extensive research of sexual assault in prisoners undertaken in Australia to date identified that 25% of 18-25 year olds in the prison population were being sexually assaulted whilst incarcerated.[47] Although the KPMG Review does not make reference to it, in Queensland, the Department of Corrective Services does acknowledge that sexual assault happens in prison and has policies and procedures to make prisoners aware of the ever present danger and their responsibility to report it. In seeking to respond appropriately QDCS policy directs that:

> Any prisoner who makes an allegation of sexual assault must be referred to a Senior Psychologist/Psychologist within 24 hours…The psychologist must assess the prisoner's level of post-assault trauma and, with prisoner consent, immediately implement a debriefing and treatment plan. The initial assessment must include an At-risk assessment.[48]

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

 Although, in the section that details best practice considerations the KPMG Review highlights 'risk factors', that increase likelihood of sexual assault in prisons - 'men who have sex with men, inter-racial violence; and history of childhood sexual abuse' – it does not articulate how the 'new way of responding' through the co-located hubs will provide a service to this group of men?

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

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

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

Young Males

Whilst the KPMG Review did not emphasise a need to design appropriate service responses to engage support and assist young people, it has been highlighted elsewhere. The Victorian Standards of Practice for Centres Against Sexual Assault emphasise the specific service delivery concerns in relation to 'Crisis Care and Counselling Issues in Working with Young People' in a way that recognises that young people have individual and diverse needs.[49] In the UK evaluation of 'Sexual Assault Referral Centres: developing good practice and maximising potentials' the 'Start Young Persons Project was identified as part of an evolving best practice response. In seeking to reach out and engage young people, 'The Havens' have developed youth friendly services and resources, such as the booklet - 'Coping with sexual assault: A guide for young people'. In Brisbane, Zig Zag Young Women's Resource Centre has for over 20 years provided direct service to young women who have experienced sexual assault and is currently funded by Queensland Health (recognising that women in the 18-24 age group are most at risk of sexual assault - Women's Safety Survey 1995). In liaising with Zig Zag, LivingWell has provided some assistance to male partners, siblings and family members of young women.

In seeking to develop a relevant service model to assist all Queenslanders it is useful to note that the World Health Organization has called for the development of youth friendly services that actively work to improve young people's access to health services. Supporting the call for specific youth friendly service, recent research has emphasized the need for sensitive services that recognize and support young people's unique stage of biological, cognitive, and psychosocial transition into adulthood.[50] Examination of help-seeking behavior indicates that young people are less willing to disclose sensitive issues (like sexual assault or childhood abuse) and turn more readily to peers, or to family members for assistance. Suggestions are that youth based services are most effective when they are:-

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

The National Men's Health discussion paper has also highlighted how service need to be adapted to become accessible to young males and that specific strategies are required to address the behaviour of young males that lead to their over representation in relation to transport accidents, workplace accidents, suicide, injury, skin cancer, accidental

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

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

poisoning, STIs, sexual identity/ gender diversity, alcohol, risky behaviour, tobacco and recreational drug use and the impact of homophobia.


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

Male sex workers

The KPMG report does not specifically recognize the high needs and unmet service delivery of male sex workers. However, previously in National government reports 'sex workers' have been identified as a group that experienced greater incidence of sexual assault than the broader community and deserving of special assistance.[51] In designing a service response to male sex workers as a victim group particularly vulnerable to sexual assault, it may be useful to consult with sexual health clinics and workers and to recognize that male sex workers experience:

- Concern in relation to confidentiality and privacy
- Fear of staff bias and negative attitudes, especially if identifying as gay or transgender
- Anxiety about moral judgment of staff
- Wish for choice of gender in practitioner
- Complex issues mixing of childhood sexual assault, psychological, mental health issues
- Drug and alcohol problems concurrent
- Transient lifestyle - making contact/counseling difficult and inconsistent,
- Accommodation needs
- Risk taking, self-harming, suicidality[52]

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

Whereas Queensland Health has a history of acknowledging the important role partners, family and friends play in supporting people who have experienced sexual violence, the KPMG Review does not provide details of how this 'support and information for partners, friends and families' might be integrated into the new way of responding (2009:54). It is recognized that partners, family and friends in providing support and understanding can play a significant role in ameliorating the impact of sexual violence and that often they require support in carrying out this role. Both Lievore (2005) and Morrison (2007) identify how the extent to which a person is affected can be shaped by the reactions of partners, spouses and family members.[53] The 'social support' of family members and the need to

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

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

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

'support the supporters' is particularly relevant given that disclosure is typically made to partners, friends, and family members prior to professional services and many 'survivors' of sexual assault will never access professional counselling and support.[54]

A difficulty for men is that research suggests that men are less likely than women to receive the positive 'social support' of family, friends and partners.[55] Whilst much research has focused on social support of women, David Denborough in talking about the dynamic impact of the sexual violence of men, notes how sexual assault produces 'ripple effects' throughout men's lives that flow on into the lives and relationships of partners, family and friends.[56] Jim Hopper PhD on his influential web site providing information in relation to the sexual assault of males highlights:

- Need to assist those whose "loved ones" have experienced abuse or assault to "sort through" their own feelings, fears,, frustrations, thoughts and ideas on how best to assist and take care of themselves in the process.[57]

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

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

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

State wide focus on prevention and community education

The KPMG Review recommendation of a state wide focus on prevention and community education is to be commended for its acknowledgement of a need to include information on 'recent assaults, childhood abuse and abuse of males'. (KPMG 2009:77). Although the development of effective, evidence based, whole of government prevention and education strategies has been a focus of recent research and government reports, to date, federal and state campaigns have been specifically directed at the serious problem of violence against women, (with $20 million allocated to the 'Australia says not to violence against

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

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

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

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

women').[58] The *National Framework for Sexual Assault Prevention* specifically identifies a need to develop 'targeted' strategies directed at specific groups of victims/survivors, including men, in a way that reduces to the ongoing health costs of sexual assault.

A useful recent report that highlights the need for a highly developed gender analysis in designing effective prevention and community education strategies is the *Framing Best Practice: National Standards for the Primary Prevention of Sexual Assault through Education* report.[59] Another report that emphasises the value of community education is 'Cry for help', which recommended:

> *that a website be developed providing advice to community members and professional regarding disclosure and help seeking behaviours, and helpful responses to disclosure of CSA by a child, an adolescent or an adult.*[60]

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


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

Research and data collection

The need for ongoing research is highlighted within the KPMG Review. The Review suggests a need to develop ongoing relationships with Universities and Hospitals, to develop and maintain relationships across jurisdictions that ensure currency in policy and practice outputs and to develop conference and academic papers that ensures linkages with sexual assault services (KPMG 2009:88). The need to develop a comprehensive research driven evidence for working with men is significant, given that, in 2002 it was "estimated that research, help, and support for male victims is more than 20 years behind that of female victims".[61] Banyard et al (2004), in outlining a way forward noted 'patterns of gender similarity and difference are important, and neither should be an exclusive focus of research questions' and further that there is a need to examine:

> *'more closely other background factors in the lives of CSA survivors that may help us understand links between CSA and more proximal adult outcomes for men, who have rarely been the subject of second and third generation studies, that have, to*

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

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

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

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

date, nearly exclusively focussed on female survivors. Such information is critical for designing appropriate services for male survivors that build on what we have learned from the experience of female survivors but also are tailored to unique aspects of men's experiences'.[62]

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

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


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

Quality Training

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

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

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

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

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

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

Opportunity to address identified gaps in current service responses

The KPMG Review identifies clear gaps in current Queensland Health responses to 'male victims', commenting that '[t]his situation is untenable and must be addressed' (2009:70). In developing this limited response to the KPMG Review, Livingwell is aware that a lack of services for men who have experienced sexual violence has previously been identified in Government documents, in internal reports and ministerial letters, without, to date, producing significant change.

In 2000, the Queensland Government Report Project Axis Child Sexual Abuse in Queensland: Responses to the Problem (2000), highlighted that there existed "Gaps in Service Provision", with a specific need "For services for male victims, both child victims and adult survivors".[63] In May 2007 Queensland Health area coordinators for Sexual Assault and Domestic and Family Violence undertook an internal mapping exercise that identified a need to introduce 'services that would more universally respond to male victims' (2009:59). In January 2008, in line with internal government reviews the previous year, Premier Anna Bligh acknowledged that:

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

In November 2008 the Victims of Crime Review Report by the Department of Justice and Attorney General again commented on a 'limited services for male sexual assault victims'.[64]

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

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

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

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