Queensland Health

Review of Queensland Health responses to adult victims of sexual assault

March 2009
This report contains 140 pages
4769976_1.DOC

Contents

Inherent Limitations

This report has been prepared as outlined in section one of this report.

The findings in this report are based on a qualitative study and the reported results reflect a perception of sexual assault service provision but only to the extent of the sample consulted. No warranty of completeness, accuracy or reliability is given in relation to the statements and representations made by, and the information and documentation provided by, stakeholders consulted as part of the process.

KPMG have indicated within this report the sources of the information provided. We have not sought to independently verify those sources unless otherwise noted within the report.

KPMG is under no obligation in any circumstance to update this report, in either oral or written form, for events occurring after the report has been issued in final form.

The findings in this report have been formed on the above basis.

Third Party Reliance

This report is solely for the purpose set out in section two of this report and for Queensland Health, and is not to be used for any other purpose or distributed to any other party without KPMG's prior written consent.

This report has been prepared at the request of Queensland Health in accordance with the terms of KPMG's contract. Other than our responsibility to Queensland Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility.

Executive summary

Introduction and background

Sexual assault is a significant issue that requires a coordinated response to manage the multiple needs of victims. This reports presents the findings of a review of Queensland Health responses to adult victims of sexual assault in Queensland. The review was undertaken to identify gaps in service provision, examine cooperation and integration of Sexual Assault Services with key agencies and provide options for a service system model that is evidenced based and that appropriately and effectively meets the needs of adult victims of sexual assault.

Sexual assault is a crime in Queensland and approximately 19,000 incidents of sexual assault were reported across the state in 2006. Reports to police over the last few years have increased although are still thought to be an under representation of the problem. The vast majority of victims of sexual assault are female and the estimated prevalence of sexual assault among male populations is 0.1 per cent (compared with 0.4 per cent for females).

The impacts of sexual assault are devastating and include both physical and emotional reactions that include anxiety, tearfulness, self blame, guilt and helplessness. Fifty per cent of victims of sexual assault may experience symptoms across their whole life span. Post traumatic stress disorder frequently follows an assault and can lead to a range of negative health impacts over time. The experience of sexual assault for men is similar to that identified for women, but also includes pervasive issues about sexuality.

The cost of violence against women is associated with increased health costs for the treatment of physical and mental conditions associated with the trauma, the production costs associated with absenteeism and second generation costs associated with the family services support sector.

There is a substantial body of knowledge that supports the need for early intervention for victims of sexual assault to identify and address emerging trauma symptoms. Crisis intervention theories cite the need for interventions that commence within 24-72 hours of the event that last approximately six weeks and have a focus on helping victims to recover mastery over their lives.

Health responses to victims of sexual assault include:

- acute or crisis care, where sexual assault has occurred within the previous 48-96 hours and the initial medical examination is conducted and counselling and support;
- forensic and follow-up medical care; and
- longer-term health responses.

These services should be provided by police, medical or nursing practitioners and counselling or support staff with expertise in sexual assault. Service responses should ideally be coordinated or co-located to ensure that the victim has access to all elements of the response.

Queensland Health responds to adult victims of sexual assault through the provision of forensic medical examinations provided by the Clinical Forensic Medicine Unit (CFMU) and counselling and support through the Sexual Assault Support and Prevention Program (SASPP program). Sexual Assault Services are located both within Queensland Health Service Districts (9 services) or are delivered through funding agreements between Queensland Health central office and 19 non-government organisations.

The CFMU employs full time Forensic Medical Officers (FMOs) to provide a broad range of forensic medicine in three locations (Brisbane, Townsville and the Gold Coast) and supervises and supports the practice of General Medical Officers (GMOs) in other parts of the state. Forensic Nurse Examiners (FNEs) are also employed by the CFMU and have been trained to undertake a range of forensic tasks. FNEs in Cairns and Townsville have recently commenced conducting forensic medical examinations of adult victims of sexual assault under the supervision of FMOs.

A Statewide Sexual Assault Helpline (operating between 7-00am and midnight) is also funded by Queensland Health central office and is operated by DV Connect under a contract to expire in June 2009.

The review of Queensland Health responses to adult victims of sexual assault has involved consultation with a limited number of stakeholders as the review is intended to identify further avenues of investigation that need to be considered in the development of new approaches. More information about the methodology of the review is at Appendix A.

Best practice elements of a contemporary response

Best practice elements of a response to victims of sexual assault are considered in relation to system design and management, and service delivery responses. The information below is based on a scan of available national and international evidence.

Service system design

Most contemporary sexual assault systems throughout Australia and internationally are based on structures that support service system integrations across health, justice and human services.

Elements of integrated service systems in other jurisdictions include:

- whole of government development of policy – this include a focus on prevention and integrated health and criminal justice responses and includes a strong focus on prevention and effective criminal justice responses;

- governance arrangements that support integration – this includes governance at a whole of government level, a service delivery integration level and at a program level; and

- a focus on quality management that comprises continuous improvement, professional development and joint training opportunities for practitioners across the systems involved in service delivery.

Service delivery responses

Health responses to victims of sexual assault include medical and forensic care and counselling and support services. Best practice elements of effective health responses include services that:

- are victim centred – victims should be able to control the pace of all interventions and make informed decisions about how the response should occur. This includes having choice about the sex of the medical examiner and whether to involve police;

- include counselling services that are available for recent victims and survivors of sexual assault – both of these service responses should be available from the one location as treatment for both groups is similar and includes the use of cognitive behavioural or group therapy approaches to reduce trauma and assimilate the impacts of the assault;

- are accessible for victims that face greater barriers to using services such as men, individuals from Indigenous and CALD communities, people in rural and remote communities, lesbian, gay, bi-sexual and transgender people, prison populations and people with a mental illness or disability;

- are provided in a way that is timely – this means that service responses should be available on a 24 hour a day basis (which is why most jurisdictions throughout Australia link their sexual assault response to hospital settings). The forensic and medical examination should also be undertaken as soon as possible following the presentation of the victim to maximise opportunities for evidence collection;

- are provided through integrated service hubs of counselling and medical services that are closely connected with criminal justice responses – different models of co-located service delivery are emerging throughout Australia, including the health lead model or justice lead co-located model. Co-located service delivery means that victims can access forensic, medical and counselling and support services from the one site. Ideally, police will also attend the victim at the same place;

- include appropriate follow up care – follow up care is necessary to address both medical and psychological issues for victims post an assault. This means that follow up appointments should be made so that professionals with expertise in sexual assault can assess the progress of the victim and implement appropriate interventions to address any issues identified;

- are provided by well trained and qualified professionals – forensic and medical examinations should only be conducted by medical or nursing professionals with specialist training in sexual assault. Counselling and support staff should have a tertiary qualification in social work, psychology or counselling and this should be supplemented with additional training in the area of sexual assault; and

- are informed by common processes and protocols across services and the system – clear and common protocols should be in place across systems to ensure that all service components understand their role in the response to victims.

A number of best practice principles have been constructed based on the findings presented above:

- the policy that underpins sexual assault services is whole of government and focuses on prevention of sexual assault and supporting effective criminal justice responses;

- institutional and governance arrangements support whole of government policy development and integrated service delivery;

- all components of the response must be victim centred and allow victims to control the pace, nature and direction of the response;

- responses will be available that respond to the needs of victims who have experienced both recent and historical assault;

- responses will be appropriate to the needs of men, women, Indigenous people, people from culturally and linguistically diverse communities and people with a disability or mental illness;

- responses must be provided in a timely manner and be accessible to all residents of Queensland 24 hours a day;

- well established and accessible entry points will facilitate the victim's pathway through a coordinated service system;

- responses are delivered in an integrated way by police, medical and nursing practitioners and counsellors, who are qualified and trained in responding to sexual assault;

- responses will be available according to clearly defined practice standards; and

- all service providers will have a clear understanding of their role in the response and this will be underpinned by clear protocols and communication processes.

Effectiveness of Queensland Health responses

Current responses to adult victims of sexual assault delivered through Queensland Health are reviewed in terms of service system elements and service delivery components.

Legislative and policy context

The legislative and policy context informing service delivery to adult victims of sexual assault include the Criminal Code Act 1899, Queensland Statewide Health Services Plan, 2007-2012, the Queensland Health Strategic Plan, 2007-2012 and the Interagency Guidelines for responding to adult victims of sexual assault (Interagency Guidelines).

The Interagency Guidelines are the key document that provides Queensland Health (and other services) with an agreed framework for responding to adult victims of sexual assault. They describe a set of overarching principles that should inform responses to victims. These are:

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

The Interagency Guidelines have not been well implemented and do not currently reflect the way in which services are delivered. There is also no current government policy that provides direction as to how the state should address sexual assault.

Institutional arrangements

Key partners in responses to adult victims of sexual assault include Queensland Health, Queensland Police and the Office of the Director of Public Prosecutions. The role of these service elements are set out in the Interagency Guidelines.

Although Queensland Health central office has played a lead role in coordinating the development of the Interagency Guidelines, there is no ongoing commitment to joint policy or practice improvements across the program areas.

Health Service Districts and Sexual Assault Services are currently providing a response to victims that is inconsistent with that detailed in the guidelines. There is a need for Queensland Health central office to engage in greater planning in relation to the service responses that are needed. Service provision should be supported by practice standards and quality improvement

mechanisms to ensure that the service that is purchased or provided is appropriate and evidence based.

Integrated governance

There are presently no standing, ongoing mechanisms for whole of government collaboration in the development of policy and the design and management of the service system. While Interagency Guidelines promote the use of sexual assault teams to respond to victims of sexual assault, these responses have not emerged in reality.

An internal mapping exercise was undertaken by the Area Coordinators for Sexual Assault and Domestic and Family Violence in 2007 and found that the Interagency Guidelines had not been comprehensively implemented. Health Service Districts appear to have played a minimal role in the implementation of the Interagency Guidelines.

Clear governance arrangements at a number of levels including statewide and at a Health Service District level would enhance the capacity of the system to respond in a collaborative and coordinated manner.

Variability of services

There are considerable variations in responses provided to victims throughout Queensland in relation to both access to forensic and medical responses and counselling and support services. For example, Sexual Assault Services located within Health Service Districts are more likely to be located in hospital grounds, provide a 24 hour service, and see male clients. Non-government Sexual Assault Services may receive funding through other sources and tend to provide a responses to women only with a focus on victims who are survivors of historical abuse. A sexual assault help line is also provided for victims but this only operates from 7-00 am until midnight. Forensic medical examinations are available through either the CFMU or via community based GMOs. Police report considerable challenges at times in locating a GMO to undertake an examination. Police also report (in one area at least) that they have been advised not to use Forensic Nurse Examiners until their credibility is tested in court.

There is an opportunity for Queensland central office to play a lead role in service planning to ensure that services are consistently available throughout the state.

Variations in service responses

The Interagency Guidelines provide guidance about what should happen when a victim of sexual assault presents at a health facility, including that ‘a forensic examination may be performed but the release of forensic information and items to police can be delayed to allow the victims more time to make a decision…’

Current practice is not consistent with the guidelines and in most areas throughout Queensland (with two exceptions) victims cannot access a forensic examination without police involvement. Service provision by Sexual Assault Services is also at odds with the Interagency Guidelines with service agreements between Queensland Health central office and non-government

services displaying considerable variability. Counselling and support services are delivered in the absence of a service provision framework and services have independently developed assessment, planning and intervention tools There is an opportunity for Queensland Health central office to introduce more robust funding and service agreements that promote effective, efficient and consistent service provision throughout the state.

Local service coordination

Health Service Districts are the mechanism through which coordination of health services at a local level occurs. The Interagency Guidelines identify Health Service Districts as being responsible for the establishment and maintenance of sexual assault teams.

Prior to the restructure of Queensland Health, coordinator positions were located within the three Area Health Services (only two were filled however and the coordinator in Central Area Health Service also provided coverage for the Northern Area Health Service) and acted as a coordination mechanism for sexual assault responses (these positions are currently located within the Policy, Planning and Resourcing Division until June 2009).

There is little evidence that Health Service Districts are playing an active role in the coordination of service delivery to victims of sexual assault as per the Interagency Guidelines. Currently, Sexual Assault Services provide services to victims of sexual assault according to their individual funding and service agreement with Queensland Health and there is little to no relationship between Health Service Districts and community based Sexual Assault Services. There is also no evidence of Health Service Districts playing a role in the coordination of forensic medical services in areas where the Clinical Forensic Medicine Unit does not have a presence.

Client entry points

Clients access a response to sexual assault via a number of entry points including through police, hospitals or Sexual Assault Services. Anecdotally, victims of recent assault appear to be most likely to seek assistance from a hospital emergency room or from the police while survivors of historical abuse tend to present at Sexual Assault Services. There is no client entry point that is consistent throughout the state. Some Sexual Assault Services have developed local level agreements with hospitals to facilitate referrals of victims presenting at hospitals but this was not evident in the majority of Sexual Assault Services talked to as part of this review.

The lack of a clear client pathway means that victims of sexual assault are at risk of not accessing a complete service. For example, it has been reported that victims reporting initially to police in areas without a CFMU may have to wait many hours for a forensic examination, and that victims presenting directly to a hospital emergency department may not necessarily be linked in to an appropriate counselling and support service.

Client group

Funding and service agreements between Queensland Health central office and Sexual Assault Services identify inconsistent client groups depending on whether the service is non-

government or based in a Health Service District. Some health based Sexual Assault Services also appear to work with male victims (despite this not being part of their service specifications). Queensland Health does not specifically fund any service to work with male victims. Male victims are currently referred to the Spiritus-Kinnections and Men Affected by Rape and Sexual Assault programs, both of which are funded through other sources. Both services report being unable to cope with the demand for service.

Stakeholders also identified significant gaps in relation to sexual assault responses to children (although responses to children were not within the scope of this review).

Indigenous victims

Murrigunyah is a community based service for Indigenous and Torres Strait Islander women and their children. Murrigunyah receives funding to respond to female victims of sexual assault aged 15 years and over. The service employs two Indigenous workers (one counsellor and one manager) with qualifications to counsel victims of sexual assault. This is the only specifically funded Indigenous sexual assault service in the state.

Murrigunyah does not appear to be adequately funded and supported to enable it to provide appropriate responses to Indigenous victims of sexual assault. The current service is located in metropolitan Brisbane and is only able to provide support to Indigenous communities in this location. Although this review did not examine specific responses to Indigenous or remote communities, feedback from stakeholders indicates that responses in remote and rural communities are inadequate and not culturally based.

Culturally and linguistically diverse backgrounds

The only sexual assault service with the specific responsibility of responding to CALD victims of sexual assault is the Immigrant Women's Support Service (IWSS) in Brisbane. IWSS describes itself as 'a feminist organisation committed to providing services that recognise and promote the rights of women of non-English speaking backgrounds and their children' who have experienced domestic violence and/or sexual assault.

Funding for the program provides for two part time counsellors who offer counselling and support for victims of sexual violence. Counsellors also provide training and support to other professionals and multicultural groups. The service also provides cross-cultural training to mainstream services, including a two day 'Developing Cross Cultural Awareness'. IWSS also develop, print and distribute information and resources to other services throughout Queensland (currently available in 17 languages). Responses to victims from CALD backgrounds are currently inadequate. Services consulted reported limited availability of interpreters (and budget to cover this expense) and the IWSS is currently unable to provide culturally appropriate supports or secondary consultation to services on a statewide basis.

Qualifications and professional development

Sexual Assault Services employ social work or psychology qualified professionals to provide therapeutic counselling interventions to victims of sexual assault. They also employ support

staff who appear to be non-qualified personnel. These staff may undertake activities such as running support groups or provide community education.

While CFMU medical and nursing practitioners undergo training in sexual assault forensic medicine, GMOs may not (although many choose to participate in the program offered through the CFMU).

Given the complex range of presenting issues for victims of sexual assault, Sexual Assault Services should only be employing appropriately qualified professionals to work with victims regardless of whether this is individual or group based or with recent or historical victims. Interventions for survivors and recent victims of sexual assault need to be informed by trauma theory and an understanding of approaches to addressing trauma. There is a need for a professional development framework for Sexual Assault Service counselling staff to ensure that knowledge about sexual assault is current. There is also a need for evidence based assessment tools and interventions to be developed and for the sector to be trained in these techniques. This will ensure more consistent evidence based service provision on a statewide basis. All medical and nursing practitioners undertaking forensic examinations of victims of sexual assault should be trained in relation to this.

The table below considers Queensland Health's response to adult victims of sexual assault against the best practice approaches identified above. Each element is rated in terms of the following categories:

- consistently in place;
- evidence in some areas; and
- no evidence that it is in place.

Queensland Health responses measured against best practice

Best practice element	**Consistently in place Evidence in some areas No evidence it is in place**
Whole of government policy that focuses on prevention and effective criminal justice responses	**Evidence in some areas**
Institutional and governance arrangements support integrated service delivery	**No evidence it is in place**
Victim centred	**Evidence in some areas**
Available to all victims of sexual assault	**No evidence is in place**
Available to victims of both recent and historical assault	**Evidence in some areas**
Provided in a way that is timely	**Evidence in some areas**

Best practice element	Consistently in place Evidence in some areas No evidence it is in place
Accessible and identifiable entry points	**Evidence in some areas**
Responses are delivered in an integrated way by well trained and qualified professionals	**Evidence in some areas**
Responses are based on clear and unambiguous practice standards	**No evidence is in place**
Processes and procedures	**Evidence in some areas**

Opportunities exist to strengthen service provision for adult victims of sexual assault in Queensland. Responses to adult victims of sexual assault in Queensland would benefit from:

- stronger leadership from Queensland Health central office at a policy and practice guidance level to drive and promote practice change;
- greater consistency in service delivery in terms of coverage and approach across the state;
- more fully integrating service delivery through stronger partnerships between police, health and justice responses. This integrated service delivery should be underpinned by common practice principles and joint professional development opportunities;
- improved focus and leadership in relation to sexual assault at a Health Service District level to ensure there is a local focus and driver to sustain partnerships and monitor practice outcomes. This leadership mechanisms could also be responsible for local communication protocols to enable effective referrals among service system partners;
- clarity of the roles of counsellors and medical and nursing practitioners in relation to crisis responses to recent victims of sexual assault. Consideration is also required as to where crisis responses should occur and how the police are involved in this response;
- statewide consistent arrangements are required for forensic medical examinations, including the involvement of police in this process and the role of Sexual Assault Services; and
- a greater emphasis on professional development standards and opportunities for staff from all disciplines involved in responding to adult victims of sexual assault (including the promotion of joint training opportunities across the sectors.

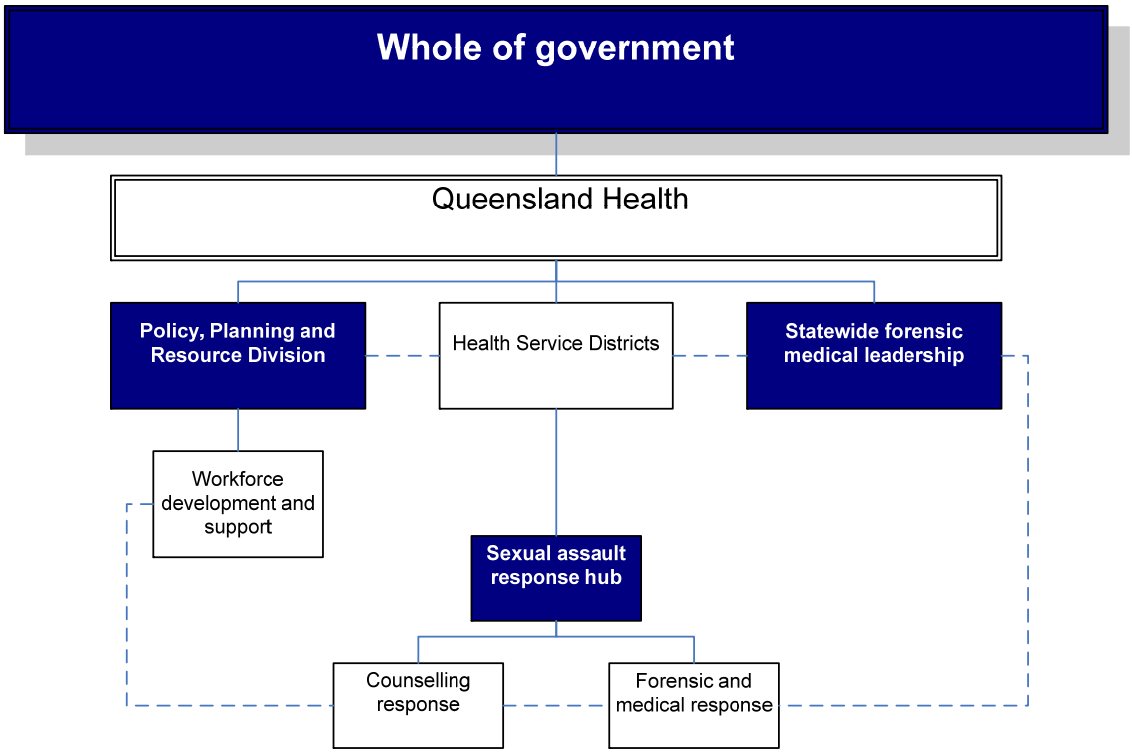
A new way of responding

The new way of responding to adult victims of sexual assault provides for a whole of government approach to service delivery reform. It is proposed that Queensland Health central office take on a stronger leadership role to promote service delivery that is evidence based and

informed by practice standards and quality assurance and monitoring mechanisms. To deliver consistent service across the state to men and women (and children) it is proposed that responses to victims of sexual assault occur through newly established sexual assault response hubs located in Health Service Districts. Quality service delivery will be supported by mechanisms at a statewide level that promote consistent practice approaches.

The core components of the new approach outlined in this section are summarised below.

Structure of the model of service provision to adult victims of sexual assault



Overview of model

The new model promotes service provision to all victims of sexual assault through sexual assault response hubs delivered through Health Service Districts. Each Health Service District would be responsible for establishing a hub or hubs and employing staff to undertake core functions such as forensic and medical examinations and counselling and support. Each hub would be responsible for establishing pathways to police and justice responses. Hubs would provide a response to male and female victims of sexual assault and work with victims of recent and past assaults (consideration may also be given to these hubs providing a response to child victims of sexual assault).

Health Service Districts will be supported in operating the hubs through a strengthened role by Queensland Health central office in relation to quality assurance, workforce development and support and the provision of policy and practice guidance to facilitate 'best practice' service

delivery approaches. Queensland Health central office will provide this through a statewide forensic medical leadership function and through establishing capacity in the Policy, Planning and Resourcing (or other appropriate) Division for supporting and developing the counselling and support workforce.

The establishment of sexual assault response hubs in Health Service Districts will deliver a health lead response to victims of sexual assault that includes forensic and medical examinations and counselling and support. Consideration will need to be given to collaboration with police and justice staff as to how and when they will respond to victims. Protocols may be established, for example, whereby police attend at the hub to take an initial statement. Or, if the victim presents to police first, the protocol should then determine that police arrange for the victim to attend at the hub for medical and counselling and support interventions.

Staffing of hubs with medical, nursing and counselling professionals trained in responding to victims of sexual assault would support consistent and high quality service provision and this would be further supported by a statewide forensic medical body and mechanisms coordinating professional development and support for counselling and support staff, as well as by leadership functions within Health Service Districts.

Hubs in each area may look different and would be dependent on the requirements of the community in which they are located. There are some examples of hub models already operating in Queensland, for example at Royal Brisbane Women's Hospital and Toowoomba Base Hospital.

In order to establish a hub or hubs in each Health Service District, Queensland Health central office (in consultation with Health Service Districts) will need to determine the need in each area and associated funding requirements. Consideration will then need to be given to redistributing funds (currently contracted to non-government or Queensland Health based Sexual Assault Services) to Health Service Districts. Tight criteria would need to be attached to these redistributed funds to ensure that service delivery that is purchased or agreed to meets appropriate standards.

Some specialist services may still be required throughout Queensland and these could be purchased from non-government agencies with specific expertise. For example, non-government Aboriginal or multi-cultural services throughout the state may be contracted to provide expert statewide secondary consultation to hubs to support their responses to Aboriginal or CALD clients. However, these services would need to demonstrate they can meet any new service specifications and contractual requirements and are able to provide a statewide secondary consultation and educative support to sexual assault response hubs. Decisions about the need for specialist service provision should be made during implementation planning.

The current 1800 line that operates from 7.00am to midnight could also be maintained to provide links for victims and other service providers to their nearest hub. Ideally, this service should be provided on a 24 hour basis also and could also be delivered through one of the hubs.

All of the above will be supported through cross departmental governance mechanisms and underpinned by statewide assessment and service planning.

Next Steps

Queensland Health central office could undertake a number of activities in the short term to bring about change, including:

- establishment of a whole of government mechanism for greater collaboration and integration of service systems;
- development of a whole of government policy framework to guide the delivery of sexual assault responses;
- consideration of the costing implications of the proposed model to inform a possible budget submission;
- undertaking an assessment of service needs and gathering evidence to determine the number and type of services required in each Health Service District; and
- development of tools to support improved management approaches.

In the medium to longer term, Queensland Health could implement the proposed changes to the service delivery model, including:

- varying funding and contractual arrangements to support the delivery of services through sexual assault response hubs in each of the Health Service Districts;
- funding and contracting with additional Sexual Assault Services outside the hubs as appropriate (eg Indigenous or CALD specific services) on the condition they are integrated with the needs and activities of the response hubs;
- resourcing and overseeing Health Service Districts to implement sexual assault response hubs;
- developing and implementing service standards and operational protocols;
- increasing its capacity to undertake effective quality management of the service response including establishing performance standards and indicators, monitoring and reporting and providing feedback to promote the continuous improvement of service providers; and
- developing and implementing a professional development framework to build the capacity of the counselling and forensic medical and nursing workforces.

1 Introduction

Sexual assault is a significant social issue that requires a range of coordinated responses to manage the multiple needs of victims. The experience of sexual assault has major consequences for the emotional and physical health of the victim over their life span. Responses to victims of sexual assault must be health focused and supported by responses from police and justice systems to appropriately manage the perpetrators of these crimes.

This report presents the findings of a review of Queensland Health responses to adult victims of sexual assault in Queensland. The review focuses on the design and management of the service system and the delivery of health services, and their links to the criminal justice and broader human services systems. It was undertaken to identify gaps in service provision, examine cooperation and integration of Sexual Assault Services with key agencies, and provide options for a service system model that is evidence based and that appropriately and effectively meets the needs of adult victims of sexual assault.

This first section of the report presents the background and context to the delivery of health related sexual assault services in Queensland. It describes the nature and extent of sexual assault in Queensland, the impact of sexual assault on victims and provides an overview of the current service response.

1.1 Nature and extent of sexual assault

Sexual assault is a crime in Queensland. The *Queensland Criminal Code Act, 1899* defines the crimes of 'rape' and 'attempted rape' as including:

- carnal knowledge without consent; and
- various forms of penetration without consent.

A separate offence of 'sexual assault' is also established, as:

- threats or intimidation of any kind to procure a person to engage in a sexual act, either in Queensland or elsewhere; or
- engaging in a sexual act with a person after administering a drug or other thing to 'stupefy or overpower the person'.[1]

At a national level, the National Crime and Safety Survey conducted through the Australian Bureau of Statistics (ABS) in 2005 estimated that there were 44,100 persons aged 18 years and over who were victims of at least one sexual assault in the 12 months prior to the survey.[2] This figure is likely to be significantly less than the true incidence due to a well established trend of

[1] Criminal Code Act (Queensland), 1899.
[2] The Australian Bureau of Statistics (ABS) defines sexual assault as a physical assault of a sexual nature, directed toward another person where that person: does not give consent; gives consent as a result of intimidation or fraud; or is legally deemed incapable of giving consent because of youth or temporary/permanent incapacity. Sexual assault includes: rape, sexual assault, sodomy, buggery, oral sex, incest, carnal knowledge, unlawful sexual intercourse, indecent assault, and assault with intent to rape.

under reporting. The estimated victimisation prevalence rate for sexual assault in Australia is 0.3 per cent of the population.[3] Approximately 72,000 incidents of sexual assault are experienced by these victims.[4] Reported sexual assaults have increased by an average of four per cent each year from 1995 to 2006.[5]

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.[6] Just over half of sexual assault victims were assaulted by someone known to them and, for 30 per cent of people identifying as sexual assault victims, the assailant had been a family member, friend or ex-partner. The next most common offenders are reportedly colleagues, neighbours and acquaintances.[7] Data collected by the National Association of Services Against Sexual Violence (NASASV) in 2000 found that 64 per cent of assaults occurred in the victim's own home, with a further 18 per cent occurring in the offender's home, and that most adults presenting to services had been the victim of rape or incest.[8]

The estimated prevalence of sexual assault among male populations is 0.1 per cent compared to 0.4 per cent for females. Males comprised 14 per cent of the estimated number of victims of sexual assault in Australia in 2002.[9]

A Personal Safety Survey was conducted by the ABS in 2005 which also included responses from males. A relevant finding of the survey revealed that Queensland had the second highest rate of sexual violence of all Australian states with the incidence as a proportion of total population at 1.9 compared to Australia as a whole at 1.6. [10]

In 2006, an estimated 19,709 assault incidents were reported in Queensland.[11] This represents just under one quarter of all reported sexual assaults throughout Australia for that year. In Queensland, sexual assaults reported to police in 2006/07 increased by seven per cent from the previous year, indicating an upward trend of reporting.[12] Overall in Australia however, rates of reporting to police remain low, with an estimated 80 per cent of sexual assaults still going unreported.[13] [14]

---

[3] The prevalence rate is calculated by dividing the number of people who have ever experienced sexual assault with the number of people in the population: Beaglehole, R, Bonita, R & Kjellstrom 1993, *Basic epidemiology*, World Health Organisation, Geneva.
[4] Australian Bureau of Statistics 2005, *Crime and Safety*, Australia, ABS Cat 4509.0, Canberra.
[5] Australian Institute of Criminology 2008, *Sexual Assault Statistics*, viewed 4 June 2008, http://www.aic.gov.au/topics/violence/sexual_assault/stats/
[6] Australian Bureau of Statistics 2003, *Sexual assault information development framework*, ABS, cat. no. 4518.0, Canberra.
[7] Australian Bureau of Statistics 2004, *Sexual assault in Australia: a statistical overview*, ABS, cat. no. 4523.0, Canberra.
8 National Association of Services Against Sexual Violence 2000, *National data collection project: report on the snapshot data collection by Australian Services Against Sexual Violence, May–June 2000*, CASA House, Melbourne.
[9] Australian Bureau of Statistics 2004, *Sexual assault in Australia: a statistical overview*, ABS, cat. no. 4523.0, Canberra.
[10] Australian Bureau of Statistics 2005, *Personal Safety Survey*, ABS, Canberra.
[11] Australian Institute of Criminology 2007, *Australian crime: facts and figures 2006*, Australian Bureau of Statistics, Canberra.
[12] Ibid
[13] Australian Bureau of Statistics 2005, *Personal Safety Survey*, ABS, Canberra.
[14] Australian Institute of Criminology 2007, *Australian crime: facts and figures 2006*, Australian Bureau of Statistics, Canberra.

1.2 Effects of sexual assault

Individuals who have experienced sexual assault suffer significant health effects, including the immediate injuries from the assault, as well as ongoing effects from chronic diseases and mental health conditions.

Reactions in the early weeks following sexual assault include strong emotional responses and a range of post-traumatic symptoms such as:

- anxiety;
- tearfulness;
- self blame and guilt;
- disbelief;
- physical revulsion; and
- helplessness.[15]

About 50 per cent of victims recover from these symptoms by 12 weeks after the assault but, in many, the symptoms persist for years.

1.2.1 Post Traumatic Stress Disorder (PTSD)

> *'Of all the traumatic stressors researched so far including natural disasters such as earthquakes, hurricanes and tsunamis, it is the 'man made' trauma of sexual violence that most strongly predicts the subsequent development of Post Traumatic Stress Disorder.'*[16]

PTSD is the development of symptoms following a traumatic event. Symptoms include:

- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
- recurrent distressing dreams of the event;
- acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated);
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;

[15] Welch, J & Mason, F 2007, 'Rape and sexual assault', *British Medical Journal*, vol. 334, pp.1154-8.
[16] Astbury, J 2006, 'Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia', Australian Centre for the Study of Sexual Assault, Melbourne.

- physiological reactions on exposure to internal or external cues that remind them of an aspect of the traumatic event; and

- persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (as indicated by efforts to avoid thoughts, feelings, or conversations associated with the trauma, efforts to avoid activities, places, or people that arouse recollections of the trauma, inability to recall an important aspect of the trauma, markedly diminished interest or participation in significant activities, feeling of detachment or estrangement from others, restricted range of affect, sense of a foreshortened future).[17]

The identification of sexual assault as a leading cause of PTSD was consolidated during the 1990s, and findings included that:

- women who have experienced sexual assault are the largest group of people to suffer from PTSD;

- victims of rape are six times more likely to experience PTSD; and

- women are more likely to experience PTSD than men post a traumatic episode.[18]

Conditions linked with PTSD following sexual assault include substance abuse, depression, anxiety disorders, eating disorders, panic and phobias, high-risk behaviours and suicide. These symptoms can result in reduced self esteem and damaged familial and social relationships. Women who have been sexually victimised as children face increased risks of subsequent rape and domestic violence in adult life and experience even higher rates of adverse health outcomes.[19]

The long term impact of stress and PTSD can make victims vulnerable to a range of serious physical health conditions including high blood pressure, heart attack, stroke, depression and aggression.[20] Studies show women who have been sexually abused use health services more than other women and they tend to assess their general health as poorer compared with women who have not experienced such violence.[21]

While male victims have attracted less attention in the literature, some research documents the impact of sexual assault on male victims, indicating that men experience: [22]

- prominent emotional affects – anger, fear, helplessness, loss, guilt and shame;

---

[17] Posttraumatic Stress Disorder DSM-IV™ Diagnosis and Criteria, viewed February 2009, http://www.mental-health-today.com/ptsd/dsm.htm.
[18] Cited in Astbury, J, 2006. Australian Centre for the Study of Sexual Assault, viewed February 2009 http://www.aifs.gov.au/acssa/pubs/issue/acssa_issues6.pdf.
[19] Fleming, J., Mullen, P., Sibthorpe, B., and Bammer, G., 1999, The long term impact of childhood sexual abuse in Australian women, *Child Abuse and Neglect*, Vol. 23, Issue 2, pp 145-159.
[20] Wilkinson, R & Marmot, M 2003, *Social Determinants of Health*, World Health Organisation, Denmark.

[21] Morrison, Z., Quadara, A., and Boyd, C., 2007. Ripple effects of sexual assault. Australian Centre for the Study of Sexual Assault, Issue No. 7, June 2007. Viewed February 2009 http://www.aifs.gov.au/acssa/pubs/issue/i7.html
[22] Hopper, J 2008, Sexual abuse of males: Prevalence, possible lasting effects and resources, viewed February 2009 http://www.jimhopper.com/male-ab

- significant cognitive distortions – inability to legitimise their experience as abuse, negative thoughts about the self and others, and self-blame;
- pervasive issues about sexuality – homosexuality and masculinity issues, problems with sexuality; and
- interpersonal difficulties – betrayal, isolation and alienation, negative childhood peer relations.

1.3 The cost of violence against women

In recent years, Victoria in particular, has gathered evidence of the social and economic costs of violence (including sexual violence) against women. These include:

- the health costs associated with treating physical and mental conditions associated with violence;
- production costs including absenteeism and lost productivity due to underperformance, poor workplace relationships and staff turnover; and
- second generation costs associated with the impact of violence on the capacity of women to parent (such as Child Protection, children's counselling, and family support services).[23]

The high incidence of mental health problems among women who have experienced violence, also contribute significantly to associated costs. In 2003 in Victoria, depression and anxiety were the leading specific cause of the burden of disease in women.

Further research by VicHealth in 2004 found that intimate partner violence is the leading risk factor to women's health, being responsible for 'more ill-health and premature death in Victorian women under the age of 45 than any other well-known risk factors, including high blood pressure, obesity and smoking.'[24] The specific elements contributing to the poor health of women affected by intimate partner violence included depression, anxiety, suicide, drug use and dangerous levels of smoking and alcohol consumption.[25]

1.4 The case for early intervention

An uncontested body of evidence now exists to indicate that sexual violence leads to a series of short term and long term negative physical health, mental health and social outcomes. There is also a substantial body of knowledge around responding to victims of trauma that calls for a

[23] Victorian Health Promotion Foundation 2008, VicHealth, Melbourne, viewed February 2009, http://www.vichealth.vic.gov.au/~/media/ProgramsandProjects/MentalHealthandWellBeing/Publications/Attachments/ResearchSummary_VAW.ashx.

[24] Ibid
[25] Ibid

response to the victim as close in time as possible to the actual event.[26] Service provision to victims of sexual assault over recent decades has been organised around crisis intervention theory which requires:

- intervention to commence within 24-72 hours of the traumatic event;
- interventions that last approximately six weeks (with the crisis period usually lasting between four and six weeks); and
- a focus on helping individuals to regain mastery over their lives.[27]

1.5 Health responses to sexual assault

The significant immediate and long-term implications of sexual abuse have implications for responses to victims and survivors. Health models are now starting to look beyond crisis care and there has been a shift to broaden service delivery from specialist, gender based services to more mainstream approaches and to integrate these with the non-health components of the sexual assault service system.

Most states around Australia have some form of protocol governing how responses to victims of sexual assault will occur. These responses are broadly categorised as:

- acute or crisis care, where sexual assault has occurred within the previous 48-96 hours and the initial medical examination is conducted and counselling and support;
- forensic and follow-up medical care; and
- longer-term health responses.[28]

Acute or crisis care must strike a balance between the victim's medical, emotional and legal needs. Victims are particularly vulnerable when they first seek to make contact after the assault and require access to services, ideally, through a single entry point. The single entry point should provide a coordinated response involving police, medical and nursing practitioners and counselling and support services. The single entry point allows victims and other service providers to more easily understand how and where to gain a response from the wider system. It should provide or coordinate access to all other components of the response. For example, if access is through the local hospital, staff there would be responsible for arranging contact from medical and counselling practitioners and for facilitating police involvement if this is wanted by the victim. Practitioners involved in a response have the following roles:

[26] Olle, L 2005 'Mapping health sector and interagency protocols on sexual assault', *Australian Centre for the Study of Sexual Assault*, vol. 2, p.5.
[27] Basic concepts in crisis theory, viewed February 2009, http://psychology.suite101.com/article.cfm/basic_concepts_in_crisis_theory.
[28] Olle, L 2005 'Mapping health sector and interagency protocols on sexual assault', *Australian Centre for the Study of Sexual Assault*, vol. 2, p.5.

- police – ensure the safety of the victim and commence an investigation into criminal activities which may have occurred;

- medical and nursing care – includes an examination to identify treatment needs, provision of medical information, support and reassurance, and coordination of appropriate referrals for ongoing physical and psychological needs. Specially trained medical and nursing practitioners are also responsible for undertaking forensic examinations of the victim to detect and collect any evidence of a crime; and

- counselling and support staff – the provision of information and support to minimise short term psychological and social negative impacts of the assault and the use of therapeutic interventions to reduce long-term consequences.

The initial medical examinations have several purposes. First and foremost, the examination provides initial treatment for injuries. Second, it facilitates the collection of forensic evidence to enable the offence to be prosecuted. Forensic medical examinations are an important part of gathering evidence to prosecute a perpetrator of a sexual assault to the criminal standard of proof (beyond reasonable doubt).

A third purpose is to provide a plan for ongoing medical care for the victim to address risks of pregnancy or of contracting sexually transmitted infections (STIs). These multiple objectives require staff with significant knowledge and experience to ensure medical examinations are conducted appropriately.

In many Australian jurisdictions, it is possible for forensic samples to be stored after collection while the victim decides whether to take legal action.[29] [30] This is seen as an important element in the response to victims of sexual assault because it gives them control over decision making about whether to report to police or not and allows them to make this decision at some point after the initial crisis.[31] [32]

1.6 Queensland Health responses

Queensland Health currently responds to adult victims of sexual assault through the provision of forensic medical examinations through the Clinical Forensic Medicine Unit (CFMU)[33] and the Sexual Assault Support and Prevention Program (SASPP program) which funds Sexual Assault Services to undertake a range of counselling and support activities in their respective local areas.

Sexual Assault Services are located both within Queensland Health Service Districts (9 services) or are delivered through funding agreements between Queensland Health central office

[29] Ibid, p7
[30] Further information about how services are configured and provided in other Australian jurisdictions is provided at Appendix B.
[31] Scott, Walker and Gilmore 1995, *Breaking the silence : a guide to supporting adult victims/survivors of sexual assault*, 2nd Edn, CASA House, Melbourne.
[32] Olle, L., D'Arcy, M. & Gridley, H 2004, 'Victim support', *Encyclopaedia of Forensic and Legal Medicine*, Elsevier, Oxford.
[33] Government Medical Officers, funded by police, also undertake forensic medical examinations.

and 19 non-government organisations throughout Queensland. The service components provided vary according to contractual or Health Service District requirements but generally include counselling and support services to female victims of sexual assault (although some health based Sexual Assault Services do see male victims). Each service is responsible for recruitment, employment, training and supervision of their staff and for the development of accountability structures and processes. Reports on client activity are provided to Queensland Health central office on a six monthly basis.

The Clinical Forensic Medicine Unit (CFMU) is part of Forensic and Scientific Services in the Clinical and Statewide Services Division within Queensland Health. The unit employs full-time Forensic Medical Officers (FMOs) to provide a broad range of forensic medical services in Brisbane, Townsville and the Gold Coast. The principal function of the FMOs is to provide clinical forensic medical services, including:

- examination of the victims of crime and of alleged offenders with a view to obtaining, documenting and interpreting medical evidence;
- examination and treatment of victims of sexual assault;
- provision of toxicological advice to police and the Courts in relation to traffic offences;
- provision of medical, including toxicological, advice to the Coroner;
- provision of medical service (e.g. telephone advice, examination and treatment) to police detainees in watch houses;
- attendance at suspicious death scenes to provide advice to police; and
- provide objective, impartial and expert evidence to courts.

In other parts of the state, local private practitioners (usually general practitioners) are appointed by the Director-General of Queensland Health as Government Medical Officers (GMOs) to undertake forensic medical examinations of victims of sexual assault. The CFMU has responsibility for recruiting, selecting and training GMOs and for ensuring consistency of practice and professional discipline. The CFMU have also commenced a process of requiring GMO appointees to participate in a process of credentialing and review of clinical privileges in the same manner as applied to full time senior medical officers with Queensland Health. This process is applied by a committee chaired by the Director of the CFMU and provides governance at the highest level, stipulating minimum basic training standards, requisite ongoing maintenance of professional skills and placing limits on the scope of practice in which an individual may engage. Examinations occur either at CFMU locations, or in hospitals or doctors surgeries and can only occur (in most sites) if police are involved. There are only two locations in Queensland where forensic evidence can be collected and stored in case victims wish to make a complaint to police at a later time.

Forensic Nurse Examiners (FNEs) are employed by the CFMU and have been trained (through the Victorian Institute of Forensic Medicine) to undertake a range of forensic medical tasks, including sexual assault examinations. FNEs in Cairns and Townsville have recently

commenced conducting forensic medical examinations of adult victims of sexual assault under the supervision of experienced FMOs (Townsville) and GMOs (Cairns). The CFMU is responsible for the selection of FNEs, and paying for their training and subsequent appointment. FNEs receive ongoing support by the Director of the CFMU pending funds for a Nurse Manager.

Training for GMOs includes five two-day residential courses covering all aspects of the role. Every GMO has been provided with the opportunity to attend this training and a majority have done so. Courses are delivered in metropolitan and rural areas and are tailored to the existing competencies and availability of local practitioners. A secure website has also been developed to support GMOs and FNEs in their practice, and a periodic newsletter is sent to all GMOs to provide information about legislative and procedural changes. The full time staff of the CFMU are available at all times to provide support to FNEs and GMOs.

The CFMU also has a statewide strategic focus that includes responsibility for strategic planning and communication with service system partners such as Queensland Police, and the John Tonge Centre.[34] The unit is in the process of making recommendations to Queensland Health about variations to the structure of the CFMU and the way in which forensic medicine is currently provided. These recommendations involve the establishment of seven forensic medical hubs located throughout Queensland from which forensic medical services can be provided on a 24 hour basis.

A Statewide Sexual Assault Helpline is also funded by Queensland Health central office and operated by DV Connect under a contract due to expire in June 2009. The service operates between 7-00am and midnight via a toll free 1800 number and provides:

- confidential support to all people who have experienced some form of sexual assault;
- support and information on the rights of victims, options, information on medical and /or forensic care; and
- information about accessing medical care and Sexual Assault Support Services and other counselling services.[35]

These services operate in a broader service system that responds to victims of sexual assault, involving police, hospitals, the Office of the Public Prosecutor and the courts. The focus of this review has been on Queensland Health responses to adult victims of sexual assault has not considered the role of the broader service network (for example, police and courts) in any detailed way.

[34] The John Tonge Centre is Brisbane's analytical laboratory with the responsibility for, among other things, examination of forensic evidence collected by forensic medical examiners.
[35] Queensland Health, Information on Statewide Sexual Assault Helpline. Provided to KPMG by Queensland Health.

1.7 The review approach

The Policy, Planning and Resourcing Division within Queensland Health engaged KPMG to review responses to adult victims of sexual assault in July 2008. The objective of this project was to review the current model and service delivery responses. This has included a high level examination of sexual assault responses provided by the 19 SASPP funded non-government Sexual Assault Services and those provided through nine services located within Health Service Districts. The aim of the project is to:

- identify gaps in service provision;
- examine cooperation and integration of Sexual Assault Services with key agencies; and
- provide options to Queensland Health for a Sexual Assault Service system model that appropriately and effectively meets the needs of adult victims of sexual assault.

Details of the methodology underpinning the review, and a list of stakeholders consulted, can be found at Appendix A. One aspect of the review included an exploration of the service elements of sexual assault systems in other jurisdictions throughout Australia. A summary of this information can be found at Appendix B.

The review of Queensland Health responses to adult victims of sexual assault is the first stage of a process aimed at ensuring that Queensland is able to provide a world's best response to victims of sexual assault that is informed by current research and contemporary practice approaches. A limited number of stakeholders have been consulted for this project, as this review is intended to identify further avenues of investigation that need to be considered in the development of new approaches. Although victims were not consulted as a part of this review, it is the intention of Queensland Health they would have a role in helping to refine the service delivery model through the implementation process, and through continuous evaluation and improvement measures once the broad parameters of the sexual assault response service system have been determined.

1.8 Terminology

Sexual Assault Services in Queensland are delivered through either 19 SASPP funded non-government organisations, or through nine services located in Health Services Districts. Throughout the report, these are referred to collectively as Sexual Assault Services. To differentiate between the two types of Sexual Assault Services, the following terms apply:

- non-government Sexual Assault Service; and
- Queensland Health based Sexual Assault Service.

Queensland Health at a central level (responsible for the development of policy, funding agreements) is referred to as Queensland Health central office.

Counselling and support functions are also referred to throughout this report. The counselling function includes the use of therapeutic interventions to help victims work through and address

post assault symptoms and trauma. The support function includes supporting victims, for example, in accessing other services or when they provide evidence in court. Both functions should be carried out by professionals with a qualification in social work, psychology, counselling or equivalent and with specific training in responding to victims of sexual assault.

1.9 Purpose of this report

This document represents a final report provided to Queensland Health at the conclusion of the review period. The report is structured as follows:

Section two	Provides an overview of contemporary research findings in relation to best practice responses to adult victims of sexual assault
Section three	Examines current responses by Queensland Health central office and Queensland Health based and non-government Sexual Assault Services in relation to service system and service delivery responses, and an analysis of performance against best practice
Section four	Provides • an introduction to a new way of responding to victims of sexual assault in Queensland • options for service system reform • options for improving service delivery responses
Section five	Provides some guidelines on next steps and approaches to implementation
Appendix A	Details the project activities and lists the stakeholders consulted for this project
Appendix B	Jurisdictional overview
Appendix C	Revised Queensland Health structure
Appendix D	Bibliography
Appendix E	Commonly used acronyms used in this report

2 Best practice elements of a contemporary response

This section presents the key themes arising from a scan of the national and international literature in relation to effective responses to the health needs of adult victims of sexual assault. It provides:

- an overview of best practice approaches to *system design and management* in other jurisdictions; and
- an overview of best practice findings and models in relation to *service delivery responses* to adult victims of sexual assault.

Best practice principles to underpin service delivery are then formulated from this evidence base.

2.1 Service system elements

The key components of the service system comprise the:

- policy and legislation that underpin services;
- institutional and governance arrangements;
- funding allocations and purchasing of services; and
- quality management processes including performance management, continuous improvement and capacity building.

Common to each of these components of system design and management, most contemporary sexual assault systems throughout Australia and comparable overseas jurisdictions are based on structures that support service system integration across health, justice and related human services. An integrated approach to sexual assault means that a seamless response is provided to victims. Integrated responses may occur because services are co-located, well networked or have strong protocols or partnerships to coordinate activity and inform the response (such as through Interagency Guidelines).

Elements of integrated service systems in other jurisdictions include:

- whole of government development of policy, which include a focus on prevention and integrated health and criminal justice responses;
- governance arrangements that support integration; and
- a focus on quality management that comprises continuous improvement, professional development and joint training opportunities for practitioners across the systems involved in service delivery.

Each of these elements is discussed below and includes, where possible, consideration of examples of how this occurs in other jurisdictions.

2.1.1 Whole of government policy

Cross government collaboration in the development of policy responses is a common feature of good practice approaches to responding to issues impacting on the safety of women and children. Research has identified that joined up or collaborative solutions to social problems are 'emerging as a significant adjunct to traditional government approaches to problem solving and service delivery'. Joined up approaches that are well resourced have been found to result in reduced duplication and enhanced consistency across initiatives.[36]

Addressing sexual assault (and other forms of violence) requires high level input from practitioners across a range of disciplines to ensure a holistic and adequate response, including police, courts and elements of the justice system, and community and government services aimed at working with women, children and perpetrators of sexual (and other forms of) violence.

Victoria has led Australia in the development of a collaborative, cross government approach to responding to violence against women and children. In 2002 the Women's Safety Strategy was launched as a whole of government policy to:

- reduce the level and fear of violence against women; and
- improve the safety, wellbeing and capacity of women to participate in Victorian life.

The strategy has a clear focus on addressing issues relating to sexual assault as it impacts on women and children. Twelve government ministers are engaged in the strategy demonstrating high level commitment to a statewide and comprehensive approach to the issue. Government departments involved in the strategy include the Department of Planning and Community Development, Department of Justice (including Victoria Police), Department of Education and Early Childhood Development, and the Department of Human Services. The Minister for Women's Affairs has a lead role in overseeing the progress of the strategy and reviews progress across departments on an annual basis and sets priorities for the coming year.

Strong focus on prevention

A further feature of best practice policy responses is an emphasis on primary prevention strategies that focus on the prevention of sexual violence before it occurs. Prevention strategies can be targeted at the population as a whole or at particular sub-groups that are at higher risk of

[36] Johnson, B, 2005, John Curtin Institute of Public Policy, Institute of Public Administration of Australia, Department of Premier and Cabinet, veiwed December 2008, http://www.jcipp.curtin.edu.au/local/docs/discussion/2005/1.05_%20Bev%20Johnson_Strategies%20for%20Joined%20Up%20Government%20Initiatives%20-%20Final.pdf.

experiencing sexual assault. Primary prevention strategies usually have an educative focus aimed at changing behaviours or understanding of the community.

Prevention strategies targeting sexual violence should also have a focus on treatment or rehabilitative programs for offenders. Victoria again appears to lead the way in Australia in relation to providing interventions specifically targeted at young offenders. A range of community based programs exist that provide therapeutic treatment programs for young people showing signs of deviant or dangerous sexual behaviour, or for young people who have been charged with an offence of a sexual nature. A number of prevention and early intervention programs have emerged under the auspice of the Sexual Assault Reform Strategy including:[37]

- treatment program for under 10 year olds – the Department of Human Services is funding a range of programs to provide early detection and treatment of children under the age of 10 who display sexually concerning, or sexually inappropriate behaviours;

- treatment program for 10 to 14 years olds – a Therapeutic Treatment Order program is being established to work with young offenders aged 10 to 14 years who have been identified by the Department of Human Services as engaging in sexually abusive behaviours;

- early intervention for 15-19 year olds – the Department of Justice is developing a voluntary treatment program for males aged between 15 to 19 years who are engaging in sexually abusive behaviour; and

- Community Safety and Sex Offenders – Community Corrections within the Department of Justice are developing initiatives to enhance supervision of sex offenders within the community.

Primary prevention and treatment programs are an essential component of a whole of government response to the issue of sexual violence. The goal of prevention and early intervention programs is to reduce the incidence of sexual violence in the community. Treatment programs must be evidence based and regularly reviewed to ensure efficacy.

Effective criminal justice responses

Traditionally, reporting rates of sexual assault amongst adult and child victims have been low. Mistrust and fear of police responses and the legal process are often identified as a major contributing factor to this under reporting.[38]

Responses to sexual assault (and other forms of violence) should be underpinned by effective, contemporary police and justice responses. A number of states in Australia have, over recent years, reviewed legislation, practice and procedures relating to criminal justice responses for cases of sexual assault.

[37] Information in relation to the Victorian Sexual Assault Reform Strategy has been sourced from a public tender document for the evaluation of the sexual assault reform strategy, November 2007.
[38] Better Health Channel, 2007, viewed December 2008, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Sexual_assault?OpenDocument.

In Victoria, the Victorian Law Reform Commission undertook an inquiry into the law and procedure in relation to sexual offences, which found low rates of reporting and prosecution despite a high incidence of offences. The inquiry also found a high rate of attrition and low conviction rate in sexual assault matters prosecuted. The report made 201 recommendations focusing on:

- improving police responses;
- increasing the responsiveness of the criminal justice system;
- making it easier for complainants to give evidence;
- improving the system for child complainants;
- improving the system for complainants who have a cognitive impairment; and
- responses to young sex offenders. [39]

This inquiry led to the establishment of the whole of government Sexual Assault Reform Strategy in Victoria which aimed to improve responses to sexual offending and victims of sexual assault through:

- a strengthened and improved criminal justice system response to sexual assault cases;
- improved support for sexual assault victims; and
- prevention and early intervention of sexual assault.[40]

New South Wales has also undertaken significant review of criminal justice responses to offenders and victims of sexual assault resulting in a range of reforms. Recent criminal justice reviews include:

- NSW Violence Against Women Specialist Unit 2005, Improving service and criminal justice responses to victims of sexual assault;[41] and
- Attorney General's Department of NSW, 2006, Criminal Justice Sexual Offences Taskforce: Responding to sexual assault: the way forward.[42]

[39] Victorian Law Reform Commission 2004, *Victorian Law Reform Commission Sexual Offences: Law and Procedure Final Report*, Victorian Law Reform Commission, Victoria.
[40] Information in relation to the Victorian Sexual Assault Reform Strategy has been sourced from a public tender document for the evaluation of the sexual assault reform strategy, November 2007.
[41] NSW Violence Against Women Specialist Unit 2006, *Improving service and criminal justice responses to victims of sexual assault*, Department of Community Services, Sydney.
[42] Attorney General's Department of NSW 2005, *Responding to sexual assault: the way forward*, Attorney General's Department NSW, Sydney.

The latter report contained a series of recommendations for reform to criminal justice responses and to the sexual assault service system, including consideration of:

- the establishment of one-stop-shops for victims of sexual assault – whereby the victim can receive appropriate medical care, counselling, have a forensic examination and talk to police in the one location;
- the appointment of a case manager within the one-stop-shop to coordinate appropriate responses for victims of sexual assault; and
- further training of Sexual Assault Nurse Examiners (SANEs).[43]

An inquiry was held into criminal justice responses to sexual assault in Queensland in 2003 and resulted in a report called *Seeking justice: an inquiry into the handling of sexual offences by the criminal justice system*. Recommendations, which were specific to criminal justice responses, from this inquiry included:

- specialist training for police members involved in responding to sexual assault;
- the establishment of an 'interagency/cross departmental working party that includes representatives from the Office of the Director of Public Prosecutions, the Department of Families and Queensland Health to assess desirable improvements' to sexual offence training accessed by police;
- changes to the police Operational Procedures Manual to provide greater clarity in relation to decision-making about prosecution;
- that senior managers within Police and Prosecutions meet regularly to discuss progression of sexual offence matters through investigation and court; and
- the establishment of formal protocols between police and other elements of the system such as the Office for the Director of Public Prosecutions.

Improving accessibility and the experiences of victims involved in the criminal justice system aims to increase the numbers of victims reporting crimes of a sexual nature to police.

2.1.2 Mechanisms for integrated governance

Responding to sexual assault requires integrated responses from counselling and support staff, medical and nursing practitioners, and police, judicial officers and legal practitioners.

Three levels of cross government collaboration have been identified in the literature. They are:

- a whole of government approach – requiring senior government representation in the identification of shared objectives and goals and the identification of a strategic approach;

[43] Ibid

- a service delivery integration approach – requiring collaborative efforts to deliver services relating to one issue or client group; and

- integration around programs – requiring efforts to 'join up the resources of organisations with similar concerns' to solve problems through a client-focused approach.[44]

Each of these levels requires separate governance and infrastructure arrangements.

The Sexual Assault Reform Strategy in Victoria which forms a significant part of the Women's Safety Strategy consists of a package of measures designed to improve the way the criminal justice and health systems respond to victims and perpetrators of sexual assault. Governance of the Sexual Assault Reform Strategy includes a range of cross-sectoral committees including:

- the Sexual Assault Advisory Committee, chaired by the Secretary of the Department of Justice, which meets quarterly;

- Department of Justice Sexual Assault Steering Committee, which oversights the whole of government strategy on a monthly basis;

- statewide Steering Committee to Reduce Sexual Assault, established under the Women's Safety Strategy and includes government, police, legal and community representatives; and

- Sexual Assault Data and Evaluation Reference Group that sits within the Department of Justice.

These groups are designed to enhance a service delivery integration approach and involve collaboration from a range of government agencies to improve service delivery to victims of sexual assault. A number of initiatives have come out of each of the above committees that focus on improving direct service delivery. Such initiatives have included:

- Victorian Policy Multi-Disciplinary Centres – one-stop-shops fore responding to adult and child victims of sexual assault. The centres provide specialised sexual assault and child abuse police investigation units, forensic services, and victim counselling and support services;

- the Sexual Offences list at the Magistrate's and County Courts – these are separate lists for managing sexual offender cases. The aim is to make trial processes more efficient and mindful of the needs of vulnerable participants such as victims and witnesses;

- Office of Public Prosecutions Specialist Sex Offences Unit – cases involving sexual assault are now prosecuted by specially trained legal staff with extensive understanding in relation to sexual assault;

- the development of a Judicial and Legal Education Framework and Sexual Assault Manual – this is a package of materials available on line to the judiciary, legal practitioners

[44] Ibid

and court staff. The package covers the investigation, prosecution and sentencing of sexual offences in Victoria;

- Victim Crisis Care and Counselling – increased funding and a focus on workforce development for the 25 sexual assault services funded to provide counselling and support for children, men and women who are the victim of sexual abuse or assault; and

- Child Witness Service – provides support to child victims or child witnesses involved in sexual assault cases before the courts.

2.1.3 Quality processes

Jurisdictions that are leading the way in reforming services to women and children affected by violence have a strong focus on quality, which encompasses performance monitoring and reporting, continuous improvement and capacity building.

For example, to effectively implement the Women's Safety Strategy[45] in Victoria, a range of performance objectives were established, including:

- coordinated planning and implementation;

- supporting continuous improvement;

- building on existing programs and services;

- recognising the important role and contribution of the community sector;

- consulting with relevant government and non-government agencies;

- reflecting the principles and policy directions of the Strategy; and

- monitoring and evaluating progress.

These objectives are reported on by government departments and monitored by the Office for Women. Victoria has also demonstrated a committed to understanding the impact of the reforms and have undertaken a number of evaluations of initiatives arising from the strategy, including an evaluation of the Women's Safety Strategy.

The Victorian Government has also recently commenced an evaluation in relation to the Sexual Assault Reform Strategy. This evaluation will focus on determining how well initiatives have functioned as a whole to support the overall aim of the Sexual Assault Reform Strategy and an examination of the extent of the benefit of the 'systems' approach to the strategy. A continuous improvement focus provides robust information about whether strategies are meeting stated objectives and achieving intended outcomes for victims.

[45] Office of Women's Policy 2002, *Acting on the Women's Safety Strategy* , Department of Premier and Cabinet, Victoria.

Contemporary models responding to victims of sexual assault also provide mechanisms for continuous improvement and capacity building. This includes professional development opportunities for practitioners, and provision of opportunities for cross-sectoral training.

The Education Centre Against Violence (ECAV) in New South Wales is a community based agency that is funded through NSW Health and is committed to enhancing 'the quality and accessibility of services to people whose lives have been affected by interpersonal violence'.[46] ECAV aims to achieve this through the provision of statewide training for NSW Health medical and counselling staff who respond to sexual violence against children and adults. ECAV also provide training to other service providers (such as police) on a fee for service basis and a statewide consultancy service to all health professionals involved in a response.

Delivering professional development opportunities to a range of staff involved in a response to victims of sexual assault, such as medical, nursing and counselling personal provides a consistent platform from which components of the system can gain a common understanding about the nature of sexual assault, and clarity about their role and responsibilities in the provision of a response. The provision of consistent training, and joint training opportunities may lead to a more cohesive service system where all service components approach victims from a similar basis.

2.2 Service delivery responses

Health based responses to adult victims of sexual assault include medical and forensic care and counselling and support services. A review of the literature suggests that best practice elements of effective health responses to victims of sexual assault:

- are victim centred;
- include counselling services that are available for recent victims and survivors of sexual assault;
- are accessible for victims that face greater barriers to using services such as men, individuals from Indigenous and CALD communities, people in rural and remote communities, lesbian, gay, bi-sexual and transgender people, prison populations and people with a mental illness or disability;
- are provided in a way that is timely;
- are provided through integrated service hubs of counselling and medical services that are closely connected with criminal justice responses;
- include appropriate follow up care;

[46] Education Centre Against Violence 2009, NSW Health, viewed November 2008, http://www.ecav.health.nsw.gov.au/.

- are provided by well trained and qualified professionals; and
- are informed by common processes and protocols across services and the system.

Each of these elements is discussed below.

2.2.1 Victim centred

A victim centred approach places the needs of the victim ahead of those of the criminal justice, or health systems. Care that is guided by the victim offers an element of control at a time when the victim is particularly vulnerable. A victim centred approach is demonstrated by:

- the provision of information about all aspects of the response;
- ensuring the victim has an opportunity to provide informed consent;
- allowing the victim to have control over the pace and nature of any physical examination and control over all decision-making;
- attention to the needs of victim sub-groups.[47] [48]

Victims should always be offered a choice in how a response should occur. Where possible, victims should also be offered a choice in the gender of the medical staff attending to them as there is evidence to indicate that both male and female victims prefer female practitioners. For example, a survey of 138 male and female victims undertaken in the United Kingdom in 2005 found that:

- 78.4 per cent of all victims indicated a preference for a female medical examiner;
- 74.6 per cent of all victims indicated a preference for a female counsellor/support worker; and
- when asked if they had no choice about the gender of the medical examiner, nearly half of the females and a quarter of the males said they would not proceed with the examination if the examiner was male. [49]

The results of this survey are consistent with previous findings.[50] [51]

[47] Tschudin, B 2005, 'Immediate care for women after sexual and physical assault', Ther Umsch, vol. 62, no. 4, pp.223-9.
[48] World Health Organisation 2003, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva.
[49] Chowdhury-Hawkins, R et al 2008, '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, pp.363-7.
[50] Temkin J. Medical evidence in rape cases: a continuing problem for criminal justice. Mod L Rev 1998;61:821–48. Cited in Chowdhury-Hawkins, R et al 2008
[51] Kelly K, Moon G, Bradshaw Y, Savage S. Insult to injury? The medical investigation of rape in England and Wales. J Soc Wel Fam L. 1998;20(4):409–20. Cited in Chowdhury-Hawkins, R et al 2008

If the gender preference of the victim is unavailable, victims should be provided with support staff sufficient to adjust the gender imbalance. Where possible, medical care should be provided by the same practitioners undertaking the forensic medical examination.

2.2.2 Counselling services are available for recent victims and survivors of sexual assault

There are two ways in which medical, counselling and support and justice services are provided to victims of sexual assault:

- **Crisis response** – are responses to a victim of sexual assault that has occurred recently (within the past week). Components of the crisis response are: a forensic medical examination, counselling and support, and police intervention if determined by the victim. Medical intervention may also be necessary if the victim has been physically injured. A crisis response always includes follow up care including medical care, and counselling and support. Victims may also require practical assistance and support such as accommodation or active referral to another service.

- **Responses to survivors of historical sexual assault** – are responses to victims of sexual assault that has occurred in the past, including assaults committed months or years previous. These responses should include counselling and support that links victims in with appropriate health care or other services (such as mental health or drug and alcohol services).

Both response pathways are needed and may involve the provision of short, medium or long-term service delivery. The crisis response is important because it can shape the victim's response to the assault, impact on their ongoing health and wellbeing, and affect legal outcomes.[52] Follow up and responses for survivors of historical abuse are important because many victims of sexual assault wait years before reporting or seeking assistance.[53]

As noted in section one, there is substantial evidence in the literature making direct links between the experience of sexual assault with a range of physical and mental health conditions including depression, anxiety, substance abuse, eating disorders and other social and behavioural problems. Childhood sexual abuse is also categorically linked with negative, lifelong outcomes for victims and survivors.

These possible outcomes have significant implications for the treatment of adult survivors of sexual assault, and there is a need to identify clear pathways for survivors to access non-crisis services through the health system.[54] Services usually required by survivors include counselling and health services to address psychological and physical conditions that have occurred as a result of past trauma. These services should be provided by specialist counsellors and medical or nursing practitioners with expertise in responding to sexual assault.

---

[52] Welch, J & Mason, F 2007, 'Rape and sexual assault', *British Medical Journal*, vol. 334, pp.1154-8.
[53] Monroe, L.M., Kinney, L.M., Weist, MD., Dafaemekpor, DS., Dantzler, J. and Reynolds, M.W., 2005. The experience of sexual assault: Findings from a statewide victim needs assessment. Journal of Interpersonal Violence, Vol 20, No. 7, p 767-776
[54] Jaycox, LH, Zoellner, L & Foa, EB 2002, 'Cognitive-behaviour therapy for PTSD in rpe survivors', *Journal of Clinical Psychology*, vol. 58, no. 8, pp.891-906.

Most Australian services that provide a response to victims of sexual assault provide a service to both recent victims of sexual assault and survivors of historical abuse. This approach appears to have a number of advantages including that expertise in sexual assault is maintained in a single service location.

Work undertaken by the Australian Institute of Family Studies has identified two treatment types that are predominant in the literature. These are:

- Cognitive therapies that seek to alter distorted cognitions. These approaches may include -
  - Cognitive Behavioural Therapy (CBT);
  - prolonged exposure therapy;
  - cognitive restructuring therapy;
  - other therapeutic services that address PTSD;
  - interventions that address victim blaming and feelings of guilt;
  - interventions that address sleep difficulties; and
  - Eye Movement Desensitisation and Reprocessing (EMDR).[55]
- Feminist or group therapy approaches. This may include -
  - stressing the importance of the social and cultural context, including gender-based oppression, in understanding the causes and nature of women's psychological difficulties;
  - helping the victim to understand that such violence is a societal problem, not just an individual problem;
  - helping the victim to understand that sexual violence is reinforced by gender-based differences in privilege and power that play out within interpersonal relationships;
  - facilitating group work with other women who have been victims, which can include activities such as art therapy, yoga, self defence, and anger management;
  - providing information on relaxation and tips on how to sleep; and
  - practical assistance such as help with letters about compensation.

Both of these approaches are used for victims of sexual assault, regardless of whether the assault was recent or historical. The focus of the work with victims may be different however,

[55] All of these therapies must only be performed by qualified professionals with skills and training in the therapeutic genre.

depending on when and how the victim presents. For example, work with a victim of recent assault may focus on cognitive behavioural interventions to attempt to avoid the development of long term trauma symptoms or PTSD, while work with a victim of assault may focus on ameliorating or reducing symptoms. Both forms of treatment should be delivered by professionals with appropriate qualifications (counselling, social work or psychology) and detailed knowledge about the impact of sexual abuse and trauma theory.

While there is a significant evidence base in relation to the efficacy of cognitive behavioural approaches, further research is needed to identity 'the precise mental health outcomes associated with the feminist, rights based approach to counselling.'[56]

2.2.3 Services are accessible

The needs of sexual assault victims were identified during the 1970s as part of the feminist rape crisis movement when the first services were established to respond to victims of sexual assault. Service users in Australia during this early period were predominantly white adult women in large urban centres where services were predominantly located.

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.

Following is a brief overview of the needs of adult victims as follows:

- male victims;
- Indigenous victims;
- victims from culturally and linguistically diverse backgrounds;
- gay, lesbian, bisexual or transgender people;
- rural and remote victims;
- victims with a disability;

[56] Astbury, J 2006, 'Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia', Australian Centre for the Study of Sexual Assault, Melbourne.

- victims with a mental illness; and
- institutionalised victims.

Male victims

The 2005 ABS Personal Safety Survey found that in the 12 months prior to the survey 0.6 per cent (42,300) of Australian men were sexually assaulted, and that 17.0 per cent (362,400) of men had been sexually assaulted at least once since they were 15. Males comprised 14 per cent of the estimated number of victims of sexual assault in Australia in 2002.

Many of these impacts of sexual assault are similar to those experienced by women. However, issues of sexuality and gender roles are far more prominent for males than females.[57] Effects of sexual assault particularly relevant to males are sexual orientation conflict, homophobia, male specific sexual dysfunction and compulsions, masculine identity confusion and fear of women.[58]

Nationally, sexual assault services for males are not comprehensive[59] and service access by male victims is very poor.

Being a victim of sexual assault can challenge the common masculine stereotype of men being able to protect themselves, and this can create difficulties for males expressing weakness or vulnerability, and seeking support.[60] 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.[61]

Debate remains about whether service responses to male victims of sexual assault should be exclusively male. Some men feel safer working with women, especially in the context of emotional repression and relationship struggles,[62] whereas others need the opportunity to explore issues of sexuality, masculinity/vulnerability and sexual behaviour with men.[63]

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'.[64]

---

[57] Australian Centre for the Study of Sexual Assault 2003, 'Male survivors of sexual assault', *Aware: newsletter of the Australian Centre for the Study of Sexual Assault*, Issue 2.
[58] Crome, S 2006, *Male survivors of sexual assault and rape*, Australian Centre for the Study of Sexual Assault, Melbourne.
59 Griffiths, M 2003, 'There is a guy on the phone, he reckons that he's been raped', Practice and Prevention: *Contemporary issues in adult sexual assault in NSW conference*, NSW Attorney-General's Department, Sydney.
[60] Crome, S 2006, *Male survivors of sexual assault and rape*, Australian Centre for the Study of Sexual Assault, Melbourne.
[61] Ellis, CD 2002, 'Male rape – the silent victims', *Collegian*, vol. 9, no. 4, pp.34-9.
[62] Chowdhury-Hawkins, R et al 2008, '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, pp.363-7.
[63] Crome, S 2006, *Male survivors of sexual assault and rape*, Australian Centre for the Study of Sexual Assault, Melbourne.
[64] Davies, M & Rogers, P 2006, Perceptions of male victims in depicted sexual assaults: A review the literature. *Aggression and Violence Behaviour, 11*, 367-377.

Indigenous victims

The issue of sexual assault in Indigenous communities has emerged in recent years as a key area of community concern. In Queensland, the 2001 Fitzgerald Inquiry into Indigenous communities at Cape York starkly illustrated the broad reach of sexual violence. It has been estimated that Indigenous women are 12 times more likely to be the victim of assault than non-Indigenous women and that Indigenous women are 45 times more likely to be a victim of domestic violence than non-Indigenous women.[65] Of the 4,606 victims of sexual assault reported in Queensland in 2006, 13 per cent (582) were Indigenous.[66]

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.[67]

There are also specific issues for Indigenous victims of sexual assault. Kinship systems and community are central to Indigenous identity, wellbeing and individual support. Sexual assault complicates these systems as, in addition to the trauma associated with the assault, there is significant loss and grief associated with disruption of kinship systems. As a result, Indigenous victims may choose not to disclose abuse perpetrated within the community or a family as this leads to the involvement of external parties through the service response.

A 2004 Victorian report identified specific barriers to access of services by Indigenous victims as:[68]

- a lack of Indigenous specific services;
- limited community awareness of services;
- institutional racism;
- fear or reprisal from the perpetrator or community;
- normalisation of assault;
- fear of police and the legal system; and
- limited skills of Indigenous community workers in responding to sexual assault.

In addition, Indigenous communities in rural and remote areas face geographical challenges in accessing services. These factors significantly reduce the likelihood of Indigenous victims receiving medical or forensic examinations after sexual assault.

---

[65] Keel, M 2004, 'Family violence and sexual assault in Indigenous communities: walking the talk', *Briefing, no. 4* September 2004 (Australian Institute of Family Studies).
[66] Australian Bureau of Statistics (2006) *Recorded Crime – Victims*, ABS Cat 4150.0, Canberra. Note that Sexual assault counts may include incidents committed prior to 2006 but reported to police in 2006.
[67] Keel, M 2004, 'Family violence and sexual assault in Indigenous communities: walking the talk', *Briefing, no. 4* September 2004 (Australian Institute of Family Studies).
[68] Thorpe, L, Solomon, R & Dimopoulos, M 2004, *From shame to pride: access to sexual assault services for Indigenous people*, Elizabeth Hoffman House and CASA House, Melbourne

Indigenous victims require culturally competent or proficient services and initiatives to address barriers to disclosure and reporting amongst the Indigenous community.

Strategies to address some of the issues identified by the literature are:

- closed courts and court support people;
- engaging Indigenous liaison workers to build the cultural proficiency of the organisation and develop outreach to Indigenous communities;
- better training and information for Indigenous workers about identifying and responding to sexual assault;
- development of a resource kit for Indigenous workers outlining the services available to victims of sexual assault;
- employment of Indigenous women in mainstream sexual assault services and use of Indigenous artwork;
- locating services in a residential location rather than more formal settings;
- allowing support people to attend counselling sessions with victims; and
- an understanding among service staff about Indigenous culture.[69]

The notion of 'cultural competence' or 'cultural proficiency' is becoming established in relation to service responses to Indigenous communities throughout Australia. This involves a process of ongoing learning, awareness of the impact of mainstream practices on Indigenous people and skill development to improve services, practice and structures.

Culturally and Linguistically Diverse victims

Australia's multicultural society includes many culturally and linguistically diverse (CALD) populations. There is little empirical research available on the subject of sexual assault of victims from CALD backgrounds. However it is reasonable to assume that, where victims are socially or culturally isolated, they may be more vulnerable to sexual assault and less likely to report. Data from the Women's Safety Survey conducted by the Australian Bureau of Statistics supports this assumption: 96 per cent of women from culturally and linguistically diverse backgrounds did not report sexual assault compared to 83 per cent of women born in Australia.

Core considerations in responding to CALD victims of sexual assault are cultural barriers as influenced by migration history, family structure, gender roles, acculturation and religious tradition,[70] along with differing definitions of violence among different cultures.[71] Because

[69] Ibid
[70] Manderson, L & Rae Bennett, L 2003, *Violence against women in Asian societies*, Routledge Curzon, New York.
[71] Sokoloff, NJ & Dupont 2005, 'Domestic violence at the intersection of race, class and gender', *Violence Against Women*, vol. 11, no. 1, pp.38-64.

CALD victims may not perceive themselves as 'victims of crime', they may not believe they have rights as victims, or as eligible for victim assistance services. Other barriers to CALD victims reporting sexual assault include language barriers, fear of retaliation and shame, and the lack of culturally specific and / or culturally proficient services.[72]

In addition to the general needs of all sexual assault victims, certain specific needs of CALD victims include:[73]

- access to and availability of female interpreters;
- linguistically appropriate information;
- cultural sensitivity and understanding; and
- appeasement of fears and apprehension regarding confidentiality.

Sexual assault services must enable access to culturally and linguistically diverse groups and ensure services are culturally competent. For example, by: ensuring information is available in multilingual formats; analysing service user and assault reports in the community and developing and implementing strategies to ensure CALD service user groups receive the information required.

Responses to lesbian, gay, bisexual and transgender people[74]

Research indicates that 2.5 to four per cent of gay men and lesbians, and 10 to 11.5 per cent of transgender people in Australia have been sexually assaulted or raped. Lesbian, gay, bisexual and transgender (LGBT) people require similar responses to others in the community, however responses must be underpinned by an understanding of the social pressures linked to issues of sexuality. Many LGBT people may delay accessing health services and may not disclose their sexuality or gender when they do. Issues impacting on decisions to access health services include practitioners lacking knowledge about LGBT health, encountering prejudice, misunderstanding or negative reactions, concerns regarding confidentiality and services being primarily focused towards responding to heterosexual clients.

The following is a summary of perceived barriers for LGBT people accessing services in Queensland:

- the majority of Sexual Assault Services do not work with men;
- gay men and transsexual people report being refused a response from Sexual Assault Services in Queensland;

[72] Lay, Y 2006, *Identifying the woman, the client and the victim*, Australian Centre for the Study of Sexual Assault, Melbourne.
[73] Graycar, AD 2000, *New research on victims of crime in Australia: Victims' needs, victims' rights, an Australian Institute of Criminology report*, Australian Institute of Criminology, Canberra.
[74] Information in this section is based on a written submission from the Queensland Association for Healthy Communities.

- lesbian women have identified being refused service because providers don't know how to address sexual violence in lesbian relationships;
- services not providing a sensitive response;
- transgender people not feeling sure if they can be accepted as clients of a Sexual Assault Service;
- the extreme sensitivity of the surgical status of transgender people; and
- the extreme sensitivity of undergoing genital examination for transgender people.

Recommendations to improve service delivery to LGBT people include:

- more accessible service provision particularly for gay men and transgender people;
- clarification about whether Sexual Assault Services work with transgender women;
- greater workforce development for staff in working with this client group;
- the development of resources to support awareness of sexual violence for the client group; and
- the inclusion of LGBT people as a target group in sexual assault policies, guidelines, reviews and consultations.

Victims in rural / remote areas

Sexual assault victims from rural and remote communities face specific issues in reporting offences and seeking assistance. Studies have identified a range of barriers for victims living in rural areas.[75] These include a lack of anonymity and higher likelihood of knowing the assailant, fewer services, mistrust of outsiders, informal social codes that enforce privacy and the protection of family reputations, and lack of knowledge about supports available.[76]

There are two main issues specific to rural sexual assault service provision: rural services cost more to provide, and practice relationships are more complex due to the higher likelihood of staff knowing both the assailant and victim.[77] [78]

[75] Lewis, SH 2003, *Unspoken crimes: sexual assault in rural America*, National Sexual Violence Resource Centre, Enola, Pennsylvania
[76] Neame, A & Heenan, M 2004, *Responding to sexual assault in rural communities*, Australian Centre for the Study of Sexual Assault, Melbourne.
[77] Ibid
[78] Ermacora, J 1998, 'It's different in the country…', *Women Against Violence: An Australian Feminist Journal*, vol. 4, pp.36-44.

Rural sexual assault victims of non-English speaking backgrounds can be particularly marginalised due to a lack of culturally appropriate responses from sexual assault service providers, including access to interpreters.[79]

The lack of easy and anonymous access to generalist sexual assault services considerably impacts on victims' capacity to access and undergo a forensic examination, resulting in under reporting, reduced contact with police and subsequent limited prosecutions.

Service provision in rural and remote areas is inherently difficult. High costs of running rural or outreach sexual assault services conflicts with smaller population pools, reduced funding and resource allocations. Recruitment to rural positions can also be significantly difficult, and qualified medical practitioners are in demand throughout rural and regional areas of the world. It is important that rural service providers work collaboratively to reduce isolation and have clear processes and protocols in place to overcome the obstacles identified above.

Victims with a disability and victims with mental illness

It has been estimated that 20 per cent of sexual assault service users in Australia have a disability of some sort.[80] Disability increases vulnerability to abuse, reducing their emotional and physical defences, recognition of abuse, and ability to protect themselves in particular situations.[81] Other factors such as economic dependence, cognitive impairment and activity limitations can also contribute to increased vulnerability.[82]

Victims with mental health issues (both acute and long term illness) may be at risk of sexual assault because of factors such as reduced inhibition towards perpetrators, an inability to make informed decisions, and exposure to potential predators when institutionalised.[83]

Barriers preventing victims with disabilities from accessing sexual assault services include:

- difficult physical access to service premises;
- reduced ability to self-disclose; and
- information not being in accessible mediums (e.g. accessible websites, TTY telephone services).

[79] Neame, A & Heenan, M 2004, op. cit.
[80] Astbury, J 2006, *Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia*, Australian Centre for the Study of Sexual Assault, Melbourne.
[81] Casteel, C et al 2008, 'National study of physical and sexual assault among women with disabilities', *Injury Prevention*, vol. 14, pp.87-90.
[82] Nosek, M et al 2001, 'Vulnerabilities for abuse among women with disabilities', *Sexuality and Disability*, vol. 19, no. 3, pp.177-89.
[83] Cybulska, B 2007, 'Sexual assault: key issues', *Journal of the Royal Society of Medicine*, vol. 100, pp.321-4.

Service responses for victims with disability or mental illness must address the following issues:

- consent is central to a medical and forensic examination of a victim, as without it the examination constitutes further assault on the victim.[84] [85] Victims with disability or mental illness may not be able to give informed consent and support workers may be required; and
- service provider premises need to be easily accessible, and information needs to be available in accessible mediums.[86]
- Consistent with a victim centred approach to responding to sexual assault, tools and techniques for medical, forensic and counselling services must be appropriate for persons with a disability and with mental illness.[87]

Victims in institutional settings

The sexual abuse of men in custodial settings such as prisons and correctional facilities is well established.[88] Official statistics, however, underestimate the true rate of these crimes.[89] The following factors and circumstances confer increased risk of sexual assault:[90]

- men who have sex with men;
- inter-racial violence; and
- history of childhood sexual abuse.

Incidence of one or more instances of sexual assault in Australian male prisoners aged 18 to 25 has been quoted as high as 25 percent.[91] However, there is no evidence that separate prisons for younger prisoners decreases the incidence.[92] A major contributing factor is the fact that male sex aggression, including that towards other males, is normalised in prisons, and extends to many institutions including the military, university campuses, schools, gangs and sporting clubs.[93]

---

[84] Welch, J & Mason, F 2007, 'Rape and sexual assault', *British Medical Journal*, vol. 334, pp.1154-8.
[85] World Health Organisation 2003, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva.
[86] Casteel, C et al 2008, 'National study of physical and sexual assault among women with disabilities', *Injury Prevention*, vol. 14, pp.87-90.
[87] Goodfellow, J & Camilleri, M 2003, 'Beyond Belief, Beyond Justice: the difficulties for victim/survivors with disabilities when reporting sexual assault and seeking justice', *Final Report – stage one of the Sexual Offences project*, Disability Discrimination Legal Service, Melbourne.
[88] Denborough, D 2005, 'Prisoner rape support package', *The International Journal of Narrative Therapy and Community Work*, vol. 2, pp. 29-37.
[89] Ibid
[90] Ibid
[91] Ibid
[92] Ibid
[93] Crome, S 2006, *Male survivors of sexual assault and rape*, Australian Centre for the Study of Sexual Assault, Melbourne.

2.2.4 Timely service provision

Responses to victims of sexual assault should be available 24 hours a day. For that reason, many jurisdictions locate sexual assault services within hospital settings. The most pressing time imperative is usually in relation to the forensic response as early examination maximises the potential for a positive criminal justice outcome.[94] One study reported that victims are three times more likely to file charges where forensic evidence has been collected. This study also illustrated the importance of the role of sexual assault forensic examiners in contributing to improved criminal justice outcomes for victims of sexual assault. A forensic and medical examination should be undertaken as soon as possible following the presentation of the sexual assault victim to maximise opportunities for evidence collection. This is widely understood to mean within one hour of attendance and within 72 hours of the alleged assault.[95]

Victims may also require a response from police and counselling staff to enhance their physical and emotional safety.

The provision of a timely response must not over ride the victim's need to control the pace of the response to the assault. Forensic and medical examinations should be available to victims and the evidence preserved, even if victims are not sure they wish to proceed with police involvement. This allows evidence to be retrieved if the victim changes their mind after subsequent counselling, support and reflection.[96] A number of states throughout Australia offer this choice, including New South Wales, South Australia and Western Australia.

2.2.5 Integrated and coordinated service delivery

Integrated and coordinated services for victims of sexual assault have now been effectively implemented in several countries, often through a co-located or 'one-stop-shop' approach which provides for medical, counselling, police, court advocacy and information services in one location.[97] Co-located service delivery has emerged nationally and internationally as the 'best-practice' model for providing an integrated response to victims of sexual assault. This approach ensures an efficient and effective crisis response to sexual assault, reducing the burden placed on the victim, and maximising the potential for timely evidence collection through interview and forensic examination by simultaneous provision of medico-legal and health services.[98]

Research indicates that victims are also more likely to access a forensic medical examination if this is available at the same location they have presented to.[99] For example, in a comprehensive evaluation in the UK in 2004 for the UK Home Office service delivery was compared across

---

[94] Saint-Martin, P, Bouyssy, M & O'Byrne P 2007, 'Analysis of 756 cases of sexual assault in Tours (France): medico-legal findings and judicial outcomes', *Medicine, Science and the Law*, vol. 47, no. 4, pp. 315-24.
[95] Lovett, J, Regan, L & Kelly, L 2004, op. cit.
[96] McGregor, M, Du Mont, J, & Myhr, T 2002, 'Sexual assault forensic medical examination: is evidence related to successful prosecution?', *Annals of Emergency Medicine*, June 2002, vol. 39, no. 6, pp. 639-647.
[97] Astbury, J 2006, op. cit.
[98] World Health Organisation 2003, op. cit.
[99] Lovett, J, Regan, L & Kelly, L 2004, *Sexual Assault Referral Centres: developing good practice and maximising potential*, Home Office Research, Development and Statistics Directorate, July 2004, UK, viewed 19 February 2007, http://www.homeoffice.gov.uk/rds/pdfs04/hors285.pdf.

areas where services were co-located and areas where services were networked. The evaluation also compared the quality of service provision across co-located and networked models. The evaluation found that:

- clients rated co-located sites much higher on measures relating to the effectiveness and conduct of forensic and medical services; and

- more clients undertook medical examinations in co-located areas than in networked areas (only 29 per cent in networked areas).

There are differences in co-located models throughout Australia and the world. For example, Victoria is currently piloting a justice lead model whereby police, counsellors and medical practitioners share a work place from which responses to adult and child victims are provided. South Australia, the Northern Territory and Western Australia have implemented the Sexual Assault Referral Centre (SARC) model developed in the United Kingdom and this constitutes a health lead co-located model. This means that medical and counselling services are provided from the one location, with the justice response being coordinated if this is what the victim chooses.

Most jurisdictions that provide co-located service responses provide a comprehensive service to victims of sexual assault that includes men, children and victims of both recent and historical assaults from the one location. Most responses to victims of sexual assault are health driven and provided by services embedded within government health systems.[100]

Jurisdictions that have implemented a co-located service response include:

- South Australia;

- Western Australia;

- Victoria;

- United Kingdom;

- United States of America; and

- South Africa.

A networked model of responding to victims of sexual assault is based on one of the main service providers (medical, counselling or police services) being the point of entry to the system, and then networking the other services around the victim. New South Wales Sexual Assault Services generally operate this way, with victims presenting to Sexual Assault Services or hospitals and the counsellor facilitating medical and police responses as appropriate.

An overview of the service delivery models in each of these jurisdictions is provided in Appendix B.

[100] See Appendix B

Co-located service provision to victims of sexual assault means that a seamless response is provided to victims that is well coordinated and delivered by professionals used to working together to provide a victim centred service. Research indicates victims are more likely to access and receive assistance when services are co-located.[101]

Comparisons between co-located models and networked models (a model whereby services are located separately but are coordinated) have found that:

- police and counselling personnel had less control over the forensic and medical examination process in the networked model;
- clients received greater support in co-located services due to the presence of a crisis support worker during the examination;
- clients rated the environment and conduct of the examiner highest at the co-located services;
- co-located services provided the most prompt and consistent services;
- notably fewer victims underwent forensic examinations under the networked model (38 per cent compared to 74 per cent);
- co-located models were better able to provide examinations and secure storage of samples for police-referrals and self-referrers who were uncertain about proceeding with a criminal justice response;
- survey participants attributed higher take up of forensic examinations at the co-located services to the presence of the crisis support workers;
- waiting times from referral to examination were lower at the co-located service – this was attributed to increased service availability through the introduction of forensic nurse examiners;
- co-located services were in a better position to provide female examiners to victims; and
- crisis support workers at integrated, co-located services were also rated higher in terms of provision of quality services and proactive follow up.[102]

Where services are not co-located, networking or coordination of services should occur. For example, in New South Wales, Sexual Assault Services generally facilitate or refer victims to medical and forensic services for treatment and forensic examination. This approach, however, does not result in a significant uptake of forensic medical examinations. Service system coordination should be underpinned by practice guidelines that provide clear information about roles and responsibilities.

[101] Lovett, J, Regan, L & Kelly, L 2004, *Sexual Assault Referral Centres: developing good practice and maximising potentials*, Home Office, London.
[102] Lovett, J, Reagan, L, & Kelly, L 2004, op. cit.

2.2.6 Appropriate follow up care

Follow-up care is necessary to address both medical and psychological issues. The World Health Organisation recommends that follow-up care be offered at two weeks, three months and six months.[103]

Even if victims do not want to seek counselling in the first instance, it is important that they know where to go to seek this at a later point in time. Follow up counselling and support programs with victims of sexual assault need to be designed to address post traumatic symptoms and promote coping. Support in a safe environment can be provided in a multitude of settings including sexual assault centres, victim support and rape crisis services, and general practitioner offices but should ideally be provided by practitioners with an understanding of sexual assault.[104]

Follow-up medical care must consider treatment for physical injuries, prevention and management of pregnancy, and identification and treatment of STIs. Follow-up care for treatment of physical injuries requires ensuring infections are prevented, and preventing pain, anxiety or insomnia may also be warranted.[105] Follow-up medical appointments should be arranged on behalf of the client.[106] Any transfer of the victim's medical care should involve a verbal or written handover between doctors.

Oral and written information should be provided to victims post a crisis response and should include:

- a summary of any physical examination;
- details and doses of any medication to be taken;
- details of any scheduled medical or counselling appointments or other referrals made;
- contact details for the nearest counselling service (if they have not been involved in the response); and
- information regarding the criminal investigation process and contact details of the relevant law enforcement officers.[107]

2.2.7 Qualified professionals

Only qualified health professionals, trained in the dynamics and impact of sexual assault, should provide responses to victims of sexual assault.[108] Counselling staff should be social work or

[103] World Health Organisation 2003, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva.
[104] Ibid.
[105] Ibid.
[106] United States Department of Justice 2004, loc. cit.
[107] Based on United States Department of Justice 2004, loc. cit.

psychology trained and have a sound understanding of appropriate assessment and intervention techniques for highly traumatised individuals. Professional supervision and performance management frameworks must be in place.

Forensic and medical examinations should only be conducted by medical or nursing practitioners with specialist training in sexual assault and forensic procedures, including the development of skills necessary to deal with victims in an appropriate and sensitive manner.[109] [110]

Forensic nursing programs have been introduced in a number of countries in response to the challenge of attracting and retaining appropriately qualified medical practitioners to conduct medical and forensic examinations of sexual assault victims. Nurses with specialist qualifications in sexual assault were first introduced in the 1970s in the US, UK and Canada and described as Sexual Assault Nurse Examiners (SANEs). The introduction of forensic nurse examiners has resulted in the following outcomes:

- increased number of examinations undertaken during daytime hours and reduced waiting times;
- improved victim psychological recovery;
- improved post-assault medical care;
- better documentation and collection of evidence;
- more comprehensive referrals to other agencies;
- increased satisfaction among police;
- improved prosecution of offences through expert testimony; and
- improved comprehensive care for victims through a multidisciplinary response. [111] [112]

The use of forensic nurse examiners is acknowledged in the literature as a best practice approach to forensic examination in cases of sexual assault.

---

[108] Australian Centre for the Study of Sexual Assault 2005, "*Good practice around Australia*", *Aware: newsletter of the Australian Centre for the Study of Sexual Assault*, no.7, June 2005, Australian Institute of Family Studies, viewed February 2009, http://www.aifs.gov.au/acssa/pubs/newsletter/n7.html
[109] Ibid.
[110] World Health Organisation 2003, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva.
[111] Martin, SL et al 2007, 'Health care-based interventions for women who have experienced sexual violence: a review of the literature', *Trauma, Violence & Abuse*, vol. 8, no. 1, pp.3-18.
[112] Campbell, R, Patterson, D & Lichty, L 2005, 'The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes', *Trauma, Violence & Abuse*, vol. 6, no. 4, pp.313-29.

2.2.8 Processes and protocols

The use of clear and common processes provides a strong foundation on which service responses can be delivered. Role clarity ensures that each sector is aware of their responsibilities and is able to provide a service within a seamless context. Common procedures in relation to intake, assessment and intervention ensure that victims receive a high quality, evidence based service regardless of where they present.

A common approach to assessing the needs of victims of sexual assault is critical to ensuring that there is equitable entry to the service system. The logic underpinning common assessment is that, regardless of where in the system the client presents, whether at a sexual assault support service, a mental health service, a private clinician or a community service, the same process is used to assess clients and determine appropriate treatment options. A common assessment process requires a standard assessment tool to determine the needs of individual clients. This tool should consider medical, justice and therapeutic needs.

Planning to respond to these needs should then occur through a common case planning approach. Such a plan should be holistic and respond to the range of issues present for the victim including medical and psychological needs. Support in relation to any criminal justice processes should be included. Plans should be regularly monitored and reviewed.

Interagency Guidelines are in place in a number of jurisdictions including New South Wales and Queensland. Interagency Guidelines provide guidance in relation to roles and responsibilities and processes to be undertaken by police, counselling and medical staff.

Practice standards should be in place to provide guidance to service system members in relation to expectations of service delivery.

2.3 Best practice principles

A number of best practice principles have been constructed based on the findings presented above:

- the policy that underpins sexual assault services is whole of government and focuses on prevention of sexual assault and supporting effective criminal justice responses;
- institutional and governance arrangements support whole of government policy development and integrated service delivery;
- all components of the response must be victim centred and allow victims to control the pace, nature and direction of the response;
- responses will be available that respond to the needs of victims who have experienced both recent and historical assault;

- responses will be appropriate to the needs of men, women, Indigenous people, people from culturally and linguistically diverse communities and people with a disability or mental illness;

- responses must be provided in a timely manner and be accessible to all residents of Queensland 24 hours a day;

- well established and accessible entry points will facilitate the victim's pathway through a coordinated service system;

- responses are delivered in an integrated way by police, medical and nursing practitioners and counsellors, who are qualified and trained in responding to sexual assault;

- responses will be available according to clearly defined practice standards; and

- all service providers will have a clear understanding of their role in the response and this will be underpinned by clear protocols and communication processes.

The following sections of this report assess the extent to which the current health service system and service delivery response for victims of sexual assault in Queensland is aligned with these best practice principles, and consider options for new approaches that would increase this alignment.

3 Effectiveness of Queensland Health responses

3.1 Introduction

This section provides an overview of the Queensland Health mechanisms and structures that underpin current responses to adult victims of sexual assault, including:

- service system elements; and
- service delivery responses.

The current response to sexual assault provided by Queensland Health is discussed in terms of the issues identified through the review and the key implications or opportunities for change. This analysis is based on evidence derived through stakeholder consultation and a review of program material.

3.2 Service system elements

Elements of the health service system for responding to sexual assault considered include the:

- legislative and policy context;
- institutional arrangements;
- governance mechanisms;
- needs assessment and planning at the whole-of-system level; and
- quality management, including performance management and capacity building.

3.2.1 Legislative and policy context

The primary piece of legislation relevant to inform responses to adult victims of sexual assault, the *Criminal Code Act 1899*, deals with offences against the person including assaults and violence generally, with Section 32 specifically addressing rape and sexual assaults.[113]

In respect of policy settings, at the highest level the Queensland Government has identified five visions for its citizens towards 2020, including:

- creating a diverse economy powered by bright ideas;
- delivering world class education and training;

[113] Australian Family and Domestic Violence Clearinghouse, viewed August 2008, http://www.austdvclearinghouse.unsw.edu.au/au_resources.html

- protecting lifestyles and the environment;
- making Queenslander's healthy; and
- supporting safe and caring communities.[114]

The Queensland Statewide Health Services Plan, 2007-2012 outlines the states plan to provide quality health services to the Queensland population.[115] The Plan identified two key areas of focus:

- improving access to safe and sustainable health services (this goal is based on a range of reforms designed to enable all Queenslanders to access safe and sustainable health services); and
- better meeting people's needs across the health continuum (focusing on the promotion of good health and healthy lifestyle choices, preventing illness and providing high quality, timely health services in the most appropriate settings).

The Queensland Health Strategic Plan, 2007-2012, identifies two strategic directions going forward that are consistent with the two outlined above.[116] Neither plan has a focus on responses to victims of sexual assault.

The *Interagency Guidelines for responding to adult victims of sexual assault* (Interagency Guidelines) is the key document that provides Queensland Health (and other services) with an agreed framework for responding to adult victims of sexual assault. They describe a set of overarching principles that should inform responses to victims. These are:

- 'all services will focus on the safety and physical and psychological needs of the victim;
- the victim's right to privacy and confidentiality will be respected at all times;
- comprehensive information about all processes and options will be offered to victims in a way which is non-judgemental, appropriate, clear and sensitive to the victim in terms of language, culture, age, disability, gender, sexuality and location;
- the victim's informed decision will be respected at every stage of the process;
- the victim's sense of personal control will be supported and encouraged;
- all relevant agencies will work collaboratively to provide clear, up to date and comprehensive information about other agencies and services and will facilitate access to those agencies and services on request;

[114] The State of Queensland 2009, Department of the Premier and Cabinet, viewed November 2008, http://www.thepremier.qld.gov.au/tomorrow/index.aspx.
[115] Queensland Health 2007, *Queensland Statewide Health Services Plan*, viewed February 2009, http://www.health.qld.gov.au/publications/corporate/stateplan2007/.
[116] Queensland Health Strategic Plan, 2003-2007. Provided to KPMG by Queensland Health.

- all agencies will ensure documentation and records are prepared in accordance with health, police and legal requirements and the need for confidentiality, security and choice'.[117]

Issues

Throughout the review it has become apparent through consultation with staff located in Queensland Health central office, and Queensland Health based and non-government Sexual Assault Services that these guidelines were not effectively implemented and that they do not currently provide an accurate description of service delivery across the state. Nevertheless, the guidelines represent the only policy document available in Queensland that provides guidance on how service delivery should occur, and some Sexual Assault Services are making attempts to act in accordance with these. The guidelines also form the basis for an integrated response to victims through encouraging Health Service Districts to provide a medical and counselling service from the one location where possible. The following section refers to the Interagency Guidelines periodically and identifies, where relevant, when service provision is not happening in accordance with these, given that they are currently the only benchmark available. Queensland service delivery is also assessed against what the literature or evidence details as 'best practice' as outlined in section 3.4.

While the whole of state plan promotes safer and healthier communities, and the Interagency Guidelines are intended to establish common principles and support coordinated service delivery, there should be a broader, more strategic policy statement that clarifies the Government's desired outcomes, principles and reform directions for responding to sexual assault.

Jurisdictions where there is evidence of real system reform (such as Victoria) have been driven by cross government development of policy and legislation as the catalyst for change. Ideally, a whole of government approach to sexual assault will consider the needs of all victims including females, males and children.

Opportunity for change

There is an opportunity for Queensland Health central office, in partnership with police and justice program areas, to develop a clear whole of government policy for sexual assault responses that:

- promotes a reduction of sexual violence in the community with consideration of assault of men, women and children;
- provides contemporary responses to all victims of sexual assault; and
- provides contemporary responses to sex offenders.

[117] Ibid, p. 9.

3.2.2 Institutional arrangements

The key agencies involved in the design and delivery of responses to adult victims of sexual assault are Queensland Health, Queensland Police and Office of the Director of Public Prosecutions. The roles of these three services are set out in the Interagency Guidelines.

The role of **Queensland Health** is to provide victims with 'medical care, forensic examinations, counselling and information.'[118] These services may be available through a number of providers including hospitals, general practitioners or Government Medical Officers (GMOs) and 'a network of specialist Sexual Assault Services who may participate in a formalised and coordinated response to assist victims of sexual assault.'[119]

Specific assistance available through Queensland Health is:

- 'medical treatment;
- collection and documentation of medico-legal evidence if appropriate;
- information, treatment options and follow-up advice to prevent and test for pregnancy and sexually transmitted infections;
- counselling immediately after an assault;
- information about rights as a victim of crime;
- information about reporting to police and legal processes;
- support and information for partners, friends and families; and
- educational and preventive programs to give other government and non-government service providers and the community a better understanding of responding to sexual assault.'[120]

All of the above services are to be provided by medical and nursing practitioners and counsellors who are specially trained in sexual assault.

The Policy, Planning and Resourcing Division within the Queensland Health central office provides policy and program leadership in relation to health responses to victims of sexual assault and policy leadership at a cross-agency level (it does not directly fund or manage non-government agencies contracted to respond to sexual assault).[121]

[118] Queensland Health, 2001, op. cit. p 12.
[119] Ibid.
[120] Ibid.
[121] Queensland Health 2008c, 'Clinical and Statewide Services Division: Role description H08CSS454', Queensland Government, Brisbane, viewed 10 September 2008, http://smartjobs.qld.gov.au/jobtools/b_fileupload.proc_download?in_file_id=6043660&in_servicecode=CUSTOMSEARCH&in_organid=14904&in_sessionid=0&in_hash_key=208B867496A22BD3.

Clinical services are delivered to the community through the Health Service Districts. At the time of undertaking this review, Queensland Health announced a statewide restructure. The restructure was effective as of 1 September 2008 and involved the abolishment of Area Health Services, and a reduction of the number of Health Service Districts from 20 to 15. A Queensland Health organisational chart post the restructure can be found at Appendix C.

Prior to the recent changes to the structure of Queensland Health, Domestic and Family Violence and Sexual Assault Service Coordinators were employed within the Southern, and Northern and Central Area Health Services. These positions had the following responsibilities:

- provision of clinical leadership;
- provision of a strategic link between family violence and sexual assault service providers;
- coordinate policy directions between family violence and sexual assault; and
- development of appropriate service delivery models to support effective responses.[122]

Under the restructure, the two remaining coordinator positions are now located in the Policy, Planning and Resourcing Division of Queensland Health until 2009.

The **Queensland Police Service** has three main functions in relation to sexual assault cases:

- 'protect and support complainants;
- investigate complaints of sexual assault and establish whether an offence of sexual assault has been committed; and
- identify, apprehend and prosecute offenders.'[123]

Police have internal guidelines that govern their response but are expected to ensure the safety of victims, provide information about other support services that are available and to keep victims informed about the investigation and any actions taken in relation to the alleged offender.

Within the **Office of the Director of Public Prosecutions**, 'the Director of Public Prosecutions represents the Crown in criminal proceedings against persons accused of committing serious criminal offences including sexual assaults.'[124] Criminal proceedings include:

- the committal hearing (the Office of the Director of Public Prosecutions only act in these matters before Magistrates in Brisbane Central, Ipswich or Southport Magistrates Courts. In other locations, committal hearings are managed by police prosecutors);
- trials over the offence;

[122] Queensland Health (2006). Bayside Health Service District, Position Description.
[123] Ibid.
[124] Ibid, p. 13.

- sentencing hearing before a judge; and
- any appeals arising from the trial or sentence.

The following other government stakeholders are involved in responding to victims and perpetrators of sexual assault:

- Justice and Attorney General's Department;
- Department of Communities;
- Department of Corrections;
- Department of Child Safety;
- Department of Education; and
- Department of Emergency Services.

The role of the **Queensland criminal justice system** sits outside the Interagency Guidelines but is an element of the overall service response to victims of sexual crimes. Approximately 500 offenders are found guilty of committing a sexual offence each year and around two-thirds of these receive a custodial sentence.[125] Intervention programs for this group are provided in custodial settings and these interventions are informed by individualised assessment and planning. Intervention programs include:

- Preparation for Intervention;
- a High Intensity Sexual Offending Program;
- a Medium Intensity Sexual Offending Intervention Program; and
- an Indigenous Sex Offender Program.

Both the Preparation for Intervention and the Medium Intensity Sexual Offending Intervention Program are also available to convicted offenders in the community. These programs, or the role of the criminal justice system (have not been part of this review).

Issues

Queensland Health central office has undertaken a whole of government coordination role in terms of developing the Interagency Guidelines which define roles and responsibilities of various agencies and key principles to guide service delivery. However, there is limited

[125] Queensland Corrective Services 2006, *Assessment, Management and Supervision of Sex Offenders in Queensland.* viewed February 2009, http://www.dcs.qld.gov.au/Publications/Corporate_Publications/Miscellaneous_Documents/SOP%20policy%20paperv5b.pdf.

evidence of ongoing policy development between Queensland Health central office and police, justice or the Department of Child Safety in relation to responding holistically to the needs of victims of sexual assault.

There are currently no practice standards or quality assurance mechanisms in place and no effective way of monitoring quality of service provision. While some data collection occurs, stakeholders identify that is very limited in nature and feedback is only received in relation to individual performance only. There is no way to currently to provide collective information about responses to victims of sexual assault.

Prior to the restructure, Queensland Health central office communicated with Sexual Assault Services through the two coordinator roles located within Health Service Districts. Overall however, stakeholders report there is little formal communication between Queensland Health central office and Queensland Health based or non-government Sexual Assault Services.

The relationship between Queensland Health central office and non-government organisations delivering a Sexual Assault Service is based on a funding and purchasing agreement. It is the role of Queensland Health central office to purchase an appropriate service and ensure that they are getting what they paid for. Stakeholder views indicate that the services purchased by Queensland Health central office do not currently adequately meet the needs of victims of sexual assault throughout Queensland. For example:

- some areas of Queensland do not have coverage by a Sexual Assault Service;
- non-government Sexual Assault Services do not provide a service to male victims and focus on responding to female victims of historical abuse;
- Sexual Assault Services have developed their own service models and tools to guide intake, assessment and intervention with clients and therefore responses are inconsistent throughout the state;
- many areas experience great difficulty in accessing a forensic medical examination through a GMO; and
- service provision is not informed by performance standards.

There is a need for Queensland Health central office to engage in greater planning in relation to the services that are needed. The introduction of performance standards and effective quality assurance measures would help Queensland Health central office be confident that services they are purchasing are appropriately provided.

Opportunity for change

There is an opportunity for Queensland Health central office to play a more active role in management of the funded sexual assault sector and liaison with other government agencies and external stakeholders. Cross government collaboration could be driven by Queensland Health central office to promote enhanced responses to all victims of sexual assault.

Greater guidance in relation to practice standards and quality assurance would also be appropriate and these arrangements could easily be built into existing funding and service agreements and into standards of service provision. Greater emphasis should also be placed on planning in relation to what services are needed throughout the state and then ensuring that service provision is consistent with this need Formal communication mechanisms between Queensland Health central office and all Sexual Assault Services would enhance cooperative relationships and result in the sector feeling more valued.

3.2.3 Mechanisms for integrated governance

There are presently no standing, ongoing mechanisms for whole of government collaboration in the development of policy and the design and management of the service system.

At the service delivery level, the Interagency Guidelines are the key existing mechanism to promote coordination of the sexual assault response with police and justice services. They describe the following features of collaboration amongst service providers involved in responding to a victim of sexual assault:

- teamwork – Queensland Health, Queensland Police Service and the Office of the Director of Public Prosecutions should have locally developed partnerships and working arrangements to facilitate collaborative responses;
- training – ongoing joint training opportunities should be in place that promote understanding of roles and objectives;
- information provision – all professionals involved in responding should be able to provide victims with comprehensive information about their role, and the role of other professionals involved in the response; and
- referrals – local procedures should be in place that enable effective referrals from and to police, health care professionals and legal services.

The guidelines promote the use of 'sexual assault teams' to respond to victims of sexual assault. These teams should consist of 'the counsellor, doctor, nurse practitioner or health worker designated to respond to victims of sexual assault in their Health Service District'.[126]

Issues

In May 2007, the Area Coordinators for Sexual Assault and Domestic and Family Violence undertook an internal mapping exercise across Southern, Central and Northern Area Health Services. The exercise included a survey of SASPP funded Sexual Assault Services and consultation with services located across the three Area Health Services. The mapping exercise showed that the Interagency Guidelines had not been comprehensively implemented and identified a need to introduce:

[126] Ibid, p. 21.

- more formal mechanisms to ensure local service coordination;
- more equitable and evidence based service coverage;
- services that would more universally respond to male victims;
- education and training to staff involved in the provision of a response; and
- greater interagency collaboration at all levels of service provision.

Feedback from stakeholders during this review confirms that guidelines appear to have been poorly implemented and there is minimal evidence that the guidelines are currently informing responses to adult victims of sexual assault.

There is very little evidence to suggest that service provision to victims of sexual assault is well integrated and coordinated. Rather, service provision appears to occur by individual services, often in isolation from other responses. For example, police indicate frequent difficulties in finding a medical practitioner to undertake a forensic medical examination in areas where there is no CFMU and Sexual Assault Services appear to be acting in isolation of health services or the police.

A number of Sexual Assault Services met with as part of this review focus on providing a service to survivors of sexual assault and do not play any role in responding to crisis presentations. This role is often left up to social workers in busy hospital emergency departments. While there is some evidence that Sexual Assault Services are attempting, at a local level, to engage with police and the court / prosecutorial staff, this appears to be limited.

Queensland Health central office does not currently play an effective governance role in the delivery of sexual assault responses to victims of sexual assault. Without a clear governance mechanism overseeing service system or service delivery responses there are currently no effective mechanisms in place to facilitate:

- cross-departmental policy development or communication;
- the collaboration of police, health and justice services; or
- coordination of responses to adults and children or more vulnerable client groups.

Clear governance mechanisms at a number of levels including a statewide, whole of system level, a service integration level and service delivery level will enhance the capacity of a range of stakeholders to more effectively contribute to improving responses to victims of sexual assault.

Opportunity for change

Clear and strong governance arrangements at a number of levels including statewide and at a Health Service District level would enhance the capacity of the system to respond in a collaborative and coordinated manner.

Statewide governance arrangements should be consistent with the best practice approaches evident in other jurisdictions and include senior representation from health, police, children's services and justice programs.

3.3 Service delivery responses

Service delivery responses considered include:

- consistency of responses;
- local coordination of service responses;
- client entry points;
- client group (including the needs of men and children);
- responses to Indigenous victims;
- responses to culturally and linguistically diverse backgrounds;
- qualifications of workers; and
- professional development of staff.

3.3.1 Variation in the availability of services

There is considerable variation in relation to the responses that Sexual Assault Services provide and therefore in the services that victims receive.

Nine of the SASPP funded Sexual Assault Services are delivered through Health Service Districts. These services are more likely to be located within hospital grounds and are often associated with other clinical programs delivered through the hospital or community health, such as Sexual Health. The health based Sexual Assault Services are more likely to see male victims and more likely to operate 24 hour roster coverage.

The 19 non-government Sexual Assault Services may or may not receive funding through other sources and provide a response to women only and predominantly those who are survivors of sexual assault or childhood abuse.

A sexual assault help line is also available statewide from 7-00 am until midnight (discussed further under section 1.6).

Reportedly, under the current funding model, there are some areas within Queensland that do not have access to a Sexual Assault Service.

Service agreements between Queensland Health and the Sexual Assault Services specify four service types that may be funded. These are:

1 Clinical service – a service provided to survivors of recent, past or childhood sexual assault provided by qualified social workers, psychologists or equivalent. The aim of the clinical service is to 'provide short term to medium term evidence based therapeutic sexual assault counselling for the resolution of the emotional and physical health impact of sexual assault'. Responses to victims of recent sexual assault should be provided as per the Interagency Guidelines. A clinical service also includes facilitating appropriate access for the victim to other relevant health services.

2 Health promotion – the provision of health promotion strategies through a range of media including printed information, telephone or face-to-face contact or via the internet. Materials should include information about the types of services available to support victims and should include information for professionals and the community about the impact of sexual assault on emotional and physical health. All health promotion materials should be regularly reviewed and evidence based, and be delivered efficiently and appropriately.

3 Support groups – the provision of time-limited, therapeutic groups where victims can meet in a safe supportive environment to address the impact of the effects of sexual assault.

4 Non-clinical counselling –support and assistance to survivors of recent and past sexual assault that may include information provision and facilitated referrals to other agencies.[127]

According to stakeholders, non-government Sexual Assault Services identify which of the above services can be provided consistent with the amount of funding they receive (as opposed to Queensland Health central office determining what services are required and funding these accordingly). This has resulted in considerable variability.

Forensic medical examinations are available through either the CFMU or via GMOs located throughout the state. Some Queensland health based Sexual Assault Services have access to medical or nursing staff through the hospital in which they are located. GMOs are not required to undertake specific training in sexual assault although many elect to do so.

Issues

There are a number of problems with the current model of funding Sexual Assault Services throughout Queensland including:

[127] Schedule 3, Performance Framework for Sexual Assault Support and Prevention Program. Provided to KPMG

- uneven distribution of services throughout Queensland with some areas receiving no or only a partial service; and

- service provision is service lead rather than based on need (that is, services indicate what services they will provide for the funding they receive).

As a consequence, services are not consistently provided across the state. For example, non-government Sexual Assault Services seem to focus on providing a response to adults who have experienced sexual assault some time in the past, while hospital based Sexual Assault Services provide a response to both recent and historical victims.

The CFMU has sites in only three locations and therefore does not have effective statewide coverage. Police identify a number of problems in relation to accessing a forensic medical examination in some areas, with limited or no GMOs available. Police in one area also identify that they are under internal direction not to use FNEs to undertake forensic examinations until their expertise to do so has been tested and proven in court. There is an ongoing challenge in recruiting and retaining GMOs to undertake forensic medicine throughout the state.

Some Sexual Assault Services play a role in responding to victims of recent assault but the majority do not. Responses to victims of recent assault are often left to hospital staff with limited support and expertise in sexual assault. The decision as to the service type provided is driven by each Sexual Assault Service (rather than by the service that is needed in each area). As a result, responses occur in different ways in different locations around the state.

Opportunity for change

Inconsistent service provision is contributed to by a range of issues (lack of governance and leadership for example) but many of the issues could be addressed through more robust funding and service agreements that promote effective, efficient and consistent service provision throughout the state and have an emphasis on implementation of evidence-based model of service; implementation of appropriate and relevant data collection mechanism to ensure results accountability; and a stronger partnership between Queensland Health central office and sexual assault service providers throughout the state.

The relationship between Queensland Health central office and Sexual Assault Services should be more than merely purchaser and provider. Rather, Queensland Health central office should be showing leadership in a range of areas such as policy development, professional development; evidence based best practice initiatives and service planning.

3.3.2 Variation in the service responses

The Interagency Guidelines state that the following should occur when a victim presents at a health facility (either with police or without):

- the sexual assault team should be notified;

- the counsellor will attend to the victim and coordinate the response;
- medical and forensic assessment is then organised (if consented to by the victim);
- if police are in attendance, the police and medical practitioner must speak prior to the examination to ensure that all evidence is collected;
- the medical practitioner will explain the purpose of the forensic and medical examination and obtain consent prior to commencing; and
- the counsellor is responsible for discussing safety needs (in the absence of police) and arranging follow up care.

The guidelines state that 'a forensic examination may be performed but the release of forensic information and items to police can be delayed to allow the victim more time to make a decision (forensic information and items must be stored securely at the health facility in accordance with local procedures)'.[128]

Issues

There are no clear practice standards informing service provision and there are no mechanisms in place at a statewide level to ensure staff are appropriately trained or supported. The Interagency Guidelines have also not been effectively implemented.

Service agreements do not specify targets for, or standards of, service provision and while qualitative reports are provided to Queensland Health central office on a six monthly basis, this information is not reported back to services in any way. Services are therefore not provided with any feedback or benchmark against which they can measure their performance.

Opportunity for change

There is an opportunity for Queensland Health central office to introduce more robust funding and service agreements that promote effective, efficient and consistent service provision throughout the state and have an emphasis on evidence based models of service provision supported by practice standards and quality assurance processes. Appropriate and relevant data collection mechanisms could also be implemented to ensure accountability.

3.3.3 Local service coordination

Health Service Districts are the mechanism through which coordination of health services at a local level occurs. The Interagency Guidelines identify Health Service Districts as being responsible for the establishment and maintenance of sexual assault teams (consisting of

[128] Ibid p. 22.

medical and nursing personal and counselling and support staff) to provide a coordinated response to victims of sexual assault presenting within a Health Service District.[129]

Prior to the restructure of Queensland Health, coordinator positions were located within the three Area Health Services (only two were filled however and the coordinator in Central Area Health Service also provided coverage for the Northern Area Health Service) and acted as a coordination mechanism for sexual assault responses (these positions are currently located within the Policy, Planning and Resourcing Division until June 2009).

Issues

There is little evidence that Health Service Districts are playing an active role in the coordination of service delivery to victims of sexual assault as per the Interagency Guidelines. Currently, Sexual Assault Services provide services to victims of sexual assault according to their individual funding and service agreement with Queensland Health and there is little to no relationship between Health Service Districts and community based Sexual Assault Services. There is also no evidence of Health Service Districts playing a role in the coordination of forensic medical services in areas where the Clinical Forensic Medicine Unit does not have a presence.

Where Sexual Assault Services are located within Health Service Districts (as opposed to within a community based organisation) service delivery appears to be more comprehensive with responses being provided to recent victims of assault and victims of historical abuse and, in at least one instance, to male victims). These Sexual Assault Services appear to have greater access to medical and nursing practitioners to conduct medical and forensic examinations and are therefore able to provide a medical / forensic and counselling response from the one hospital or community health location.

Opportunity for change

While the Interagency Guidelines promote coordinated service delivery, poor implementation means that they are not being followed and that victims are receiving a fragmented service in most locations, characterised by separate police, medical and counselling interventions.

There is an opportunity for Health Service Districts to take a lead role in relation to the coordination or integration of service delivery at a local level. A local planning and coordination mechanism would enhance communication between components of the system and provide a monitoring and quality control function that ensures consistency of responses at a local and statewide level.

Contemporary responses to victims of sexual assault are moving towards integrated responses, ideally from the one location where the victim is able to access a medical, forensic, police and counselling response from the one service. Co-located service delivery through sexual assault centres or hubs are being established in many jurisdictions throughout the world. In fact, Multi-Disciplinary Centres have been piloted in Victoria and are currently being evaluated. Evidence

[129] Consultation with Health Service Districts was extremely limited therefore generalisations about the role they do or do not play are not possible.

from the United Kingdom, Canada and the United States of America indicates that one-stop-shop locations improve the likelihood of victims accessing a service post a recent assault. Appendix B provides an overview of how services are provided across Australia and indicates that sexual assault responses are hospital based in Victoria, New South Wales, South Australia and Western Australia. This means that victims can access a forensic medical response and counselling response from the one location.

3.3.4 Client entry points

Clients access a response to sexual assault via a number of entry points including through police, hospitals or Sexual Assault Services. Victims of recent assault appear to be most likely to seek assistance from a hospital emergency room or from the police while survivors of historical abuse tend to present at Sexual Assault Services. There is no client entry point that is consistent throughout the state. Some Sexual Assault Services have developed local level agreements with hospitals to facilitate referrals of victims presenting at hospitals but this was not evident in the majority of Sexual Assault Services talked to as part of this review.

Issues

Victims of sexual assault are at risk of not accessing a service. Pathways to access a forensic medical examination are, in some locations, difficult to navigate and appear to be different depending on location, and whether there is a CFMU in the area. It has been reported that victims presenting to police or hospitals sometimes have to wait for many hours for a GMO to become available to conduct a forensic examination, or have to travel to a hospital location where there is a CFMU or other mechanism in place. Stakeholders report that victims accessing a medical response through a hospital are not necessarily linked in with a Sexual Assault Service on discharge. While information may be provided to victims about Sexual Assault Services, there are few mechanisms in place to support a formal handover.

Opportunity for change

The identification of an accessible and identifiable pathway to access a response is identified in the literature as an important element in the provision of a service to victims of sexual assault. While the Interagency Guidelines provide some guidance in relation to this, they have been poorly implemented at a local level and arrangements throughout the state are therefore ad hoc. Many jurisdictions throughout Australia locate sexual assault services within hospital settings to ensure that they are accessible, identifiable and available on a 24 hour basis.

3.3.5 Client group

Funding and service agreements between Queensland Health and Sexual Assault Services identify inconsistent client groups depending on where the service is located.

The client group for Sexual Assault Services differs as follows:

- health based Sexual Assault Services will see female clients aged 14 years and up; while
- non-government Sexual Assault Services see female victims aged 15 and above.

Some Sexual Assault Services in Health Service Districts are providing a service to men but this appears to be rare.

Many non-government Sexual Assault Services access funding through other sources to enable them to provide a response to children, however, this is on an agency by agency basis.

A number of Sexual Assault Services are funded for a specific client group, for example, Zig Zag provides sexual assault services to young women aged between 12 and 25 years.

Non-government Sexual Assault Services tend to have a focus on working with survivors of historical sexual abuse or assault and do not appear to play an active role in supporting victims of recent assault through the initial crisis presentation (this is left up to hospitals or police).

Queensland Health does not currently fund specific programs to respond to male victims of sexual assault (although some SASPP funded services will see men this is limited and not part of their service agreements). Two programs that do provide counselling and support to male victims are Brisbane based and funded by other government departments – these are Men Affected by Rape Sexual Assault (MARS) and Spiritus-Kinnections. Both of these services report that they are unable to provide an adequate response to male victims of either sexual assault or childhood abuse due to a lack of funding and resources.

Queensland Health does not provide any funding to male victims of sexual assault. While some funding is provided through other government departments it is not sufficient to enable an appropriate response to male victims of sexual assault. Male victims are not currently reporting sexual assaults to police in Queensland and there is limited understanding of this issue among service providers. The situation in relation to service responses for men in Queensland is entirely inadequate.

In his submission to this review, Dr Wendell Rosevear, founder of MARS provided the following information in relation to the needs of male victims of sexual assault:

- he has cared for 1028 male victims of sexual assault in Queensland since 1991 with 80 of these men being in prison;
- approximately half of these men present with childhood sexual abuse; and
- he periodically has to close his books because he is unable to meet the demand for service.

Sexual Assault Services identified the challenge of trying to refer male victims to an appropriate service and indicated that the options for this are extremely limited. Referrals will often be made to private practitioners but that there is a risk associated with this in that the practitioner's level of understanding and expertise in working with victims of sexual assault is unknown.

Sexual Assault Services consulted generally identified that there is a need to establish a separate pathway for male victims of sexual assault, indicating that it is preferable to maintain community based Sexual Assault Services as women only services. This view was not necessarily shared by Sexual Assault Services located within Health Service Districts some of which are already providing a service to male victims.

Most stakeholders identified a need for communication and collaboration between funding bodies of adult and child services (Queensland Health and the Department of Child Safety) to more consistently provide services to children. Sexual Assault Services that receive funding through Child Safety to work with children who have been abused reported frustration that the funding is only available while the child is a client of the department. There is no clear pathway for children who have been sexually abused but are not a client of the Department of Child Safety although responses are likely to be available through hospital social work departments.

Opportunity for change

Clarity is required in relation to the appropriate client group for Sexual Assault Services. There is no doubt that a medical, forensic and counselling and support service should be available to all citizens of Queensland including men and children. Jurisdictions providing a co-located response to victims of sexual assault tend to provide a one-stop-shop service for all victims of sexual assault including men and children. This has the benefit of not duplicating service provision across agencies and of maintaining expertise about sexual assault within the one location.

3.3.6 Responses to Indigenous victims

Murrigunyah is a community based service for Indigenous and Torres Strait Islander women and their children. Murrigunyah receives SASPP funding to respond to female victims of sexual assault aged 15 years and over. The service employs two Indigenous workers (one counsellor and one manager) with appropriate qualifications to counsel victims of sexual assault, and it has been their experience that patience is core to allowing Indigenous victims to disclose. This is the only specifically funded Indigenous sexual assault service in the state.

Issues

The one Indigenous specific service in Queensland is inadequately funded and supported to provide appropriate responses to Indigenous victims of sexual assault. The current service is located in metropolitan Brisbane and is only able to provide support to Indigenous communities in this location. Other parts of the state have no access to Indigenous specific sexual assault services.

Although this review did not examine specific responses to Indigenous communities, feedback from stakeholders indicates that responses in remote and rural communities are inadequate and not culturally based.

There is no evidence of leadership from Queensland Health central office on the issue of sexual abuse and assault in Indigenous communities.

Opportunity for change

Consideration is required in relation to the location and placement of Indigenous specific services. The current Indigenous specific service to respond to women and children who have been victims of sexual assault is Brisbane based and unable to provide support to communities or services in other parts of Queensland. A victim centred response to Indigenous women requires that all Sexual Assault Services are culturally competent and can demonstrate sound understanding (and evidence of this understanding) about Indigenous culture. Sexual Assault Services throughout Queensland require support and education in order to achieve this.

3.3.7 Responses to culturally and linguistically diverse backgrounds

The only sexual assault service with the specific responsibility of responding to CALD victims of sexual assault is the Immigrant Women's Support Service (IWSS) in Brisbane. IWSS describes itself as 'a feminist organisation committed to providing services that recognise and promote the rights of women of non-English speaking backgrounds and their children' who have experienced domestic violence and/or sexual assault.[130]

SASPP funding for the program provides for two part time counsellors who offer counselling and support for victims of sexual violence. Counsellors also provide training and support to other professionals and multicultural groups. The service also provides cross-cultural training to mainstream services, including a two day 'Developing Cross Cultural Awareness'. IWSS also develop, print and distribute information and resources to other services throughout Queensland (currently available in 17 languages).

Issues

Responses to victims from CALD backgrounds are currently inadequate. Services consulted reported limited availability of translators (and budget to cover this expense) and the IWSS is currently unable to provide culturally appropriate supports or secondary consultation to services on a statewide basis.

Opportunity for change

A victim centred response will ensure that CALD victims of sexual assault have access to an interpreter for all aspects of the response and that services providing the response can demonstrate some understanding of their culture. Sexual Assault Services throughout Queensland require education and support to achieve this (including financial support in relation to the cost of interpreters).

[130] Migrant Women's Emergency Support Services, Annual Report 2006, p. 9.

3.3.8 Qualifications and professional development

While this review has not undertaken an audit of the qualifications of Sexual Assault Service or forensic medical staff, the following information has been provided:

- Sexual Assault Services employ qualified social work or psychology staff to provide therapeutic counselling interventions to victims of sexual assault;
- Sexual Assault Services employ non-qualified personnel in some instances but these staff do not provide individual therapeutic interventions. Rather, non-qualified staff may run support groups or engage in community education activities;
- CFMU medical and nursing practitioners have specific qualifications in forensic medicine; and
- GMOs conducting forensic and medical examinations have not necessarily undergone training in responding to victims of sexual assault.

The provision of a clinical service requires that staff must be qualified in either social work or psychology or other equivalent tertiary qualification. There is no current minimum qualification requirement for staff engaging in health promotion, support groups or non-clinical counselling activities.

Professional development of staff occurs on an ad hoc basis. Each Sexual Assault Service is responsible for the professional development of their own staff and achieve this through enrolment in community or government training programs as they are available and if very limited training budgets allow.

Issues

Given the complex range of presenting issues for victims of sexual assault, Sexual Assault Services should only be employing appropriately qualified professionals to work with victims regardless of whether this is individual or group based or with recent or historical victims. Interventions for survivors and recent victims of sexual assault need to be informed by trauma theory and an understanding of approaches to addressing trauma.

There is no professional development framework for Sexual Assault Service counselling staff and no current requirement to ensure that knowledge about sexual assault is current. Staff are undertaking assessments and interventions of a complex nature without reference to a common theoretical basis or understanding. There is a need for evidence based assessment tools and interventions to be developed and for the sector to be trained in these techniques. This will ensure more consistent evidence based service provision on a statewide basis.

Training in sexual assault is not compulsory for GMOs.

Opportunity for change

It is important in the provision of a best practice response to victims of sexual assault that all personnel involved in the response are appropriately qualified to manage the complexities of sexual assault. Non-qualified staff working in Sexual Assault Services should not be undertaking any client work. It is important that all GMOs undertaking sexual assault forensic examinations are trained in this area.

There is an opportunity for Queensland Health to introduce a professional development framework that provides a focus on ongoing education and training in relation to sexual assault. The framework should be evidence based and provide joint training opportunities for medical, nursing and counselling personnel (and may also include police and court staff).

Tools should be developed to support consistent and evidence based assessment, planning and interventions with victims of sexual assault.

3.4 Summary of findings

The review into Queensland Health responses to adult victims of sexual assault has identified a number of issues that impact on the quality of the service delivered.

In terms of overall governance, Queensland Health central office is not currently providing strong leadership across government programs and across the service delivery sector, and there is no clear mechanism by which the system is governed. A lack of attention to service planning and the need for evidence based practice has resulted in a lack of robustness in service agreements with non-government providers. As a result there is little confidence that the scarce resources available are being appropriately targeted and services effectively implemented. These agreements have reportedly remained unchanged for many years. As a result, service provision occurs differently in locations throughout the state. Health Service Districts within Queensland Health have failed to play an active role in leading responses to victims of sexual assault and Interagency Guidelines developed in 2002 have been poorly implemented.

There is little to no evidence of cross sectoral communication at a statewide or Health Service District level, although some local services have made attempts to engage with other service providers locally to develop communication and service delivery protocols. Some Sexual Assault Services appear to work with children through separate funding agreements with other government departments but there is little evidence of communication between Queensland Health and such funding bodies (for example, the Department of Child Safety) about service provision arrangements.

There are some clear gaps in service delivery:

- services are available to women only and there are no Queensland Health funded services for male victims. This situation is untenable and must be addressed urgently;

- non-government Sexual Assault Services tend to focus their work on survivors of historical abuse and are not actively involved in supporting victims of recent assault. There is some

evidence that victims presenting to hospitals or police in the first instant after an assault are not receiving appropriate follow up counselling support or a coordinated response;

- services to Indigenous victims are very limited and there is a need for a strong Queensland Health focus on the issue of sexual assault in Indigenous communities. The one Indigenous specific sexual assault service is located in Brisbane and inadequately funded and supported to enable it to play a role in supporting communities in other parts of the state; and

- forensic and medical services to victims of sexual assault are delivered through the CFMU that is only located in three areas throughout the state or by GMOs or FNEs in some areas. There is little evidence of effective communication between the CFMU and Sexual Assault Services in these areas.

In summary, the table below considers Queensland Health's response to adult victims of sexual assault against the best practice approaches identified in section two. Each element is rated in terms of the following categories:

- consistently in place;

- evidence in some areas; and

- no evidence that it is in place.

Table 3: Queensland Health responses measured against best practice

Best practice element	**Consistently in place Evidence in some areas No evidence it is in place**
Whole of government policy that focuses on prevention and effective criminal justice responses	**Evidence in some areas**
Institutional and governance arrangements support integrated service delivery	**No evidence it is in place**
Victim centred	**Evidence in some areas**
Available to all victims of sexual assault	**No evidence is in place**
Available to victims of both recent and historical assault	**Evidence in some areas**
Provided in a way that is timely	**Evidence in some areas**
Accessible and identifiable entry points	**Evidence in some areas**
Responses are delivered in an integrated way by well trained and qualified professionals	**Evidence in some areas**

Best practice element	Consistently in place Evidence in some areas No evidence it is in place
Responses are based on clear and unambiguous practice standards	**No evidence is in place**
Processes and procedures	**Evidence in some areas**

Responses to adult victims of sexual assault in Queensland would benefit from:

- stronger leadership from Queensland Health central office at a policy and practice guidance level to drive and promote practice change;
- greater consistency in service delivery in terms of coverage and approach across the state;
- more fully integrating service delivery through stronger partnerships between police, health and justice responses. This integrated service delivery should be underpinned by common practice principles and joint professional development opportunities;
- improved focus and leadership in relation to sexual assault at a Health Service District level to ensure there is a local focus and driver to sustain partnerships and monitor practice outcomes. This leadership mechanisms could also be responsible for local communication protocols to enable effective referrals among service system partners;
- clarity of the roles of counsellors and medical and nursing practitioners in relation to crisis responses to recent victims of sexual assault. Consideration is also required as to where crisis responses should occur and how the police are involved in this response;
- statewide consistent arrangements are required for forensic medical examinations, including the involvement of police in this process and the role of SASPP funded Sexual Assault Services;
- a greater emphasis on professional development standards and opportunities for staff from all disciplines involved in responding to adult victims of sexual assault (including the promotion of joint training opportunities across the sectors.

In addition, there is an opportunity for Queensland Health central office to redirect existing funds to achieve a best practice service response through the consolidation of the SASSP funding within Health Service Districts (as outlined in the proposed model in section four) rather than continuing to deliver fragmented, uncoordinated responses through community based services.

The following sections of this report outline a new approach for responding to the opportunities for change and enhancing the quality of sexual assault responses across the State.

4 A new way of responding

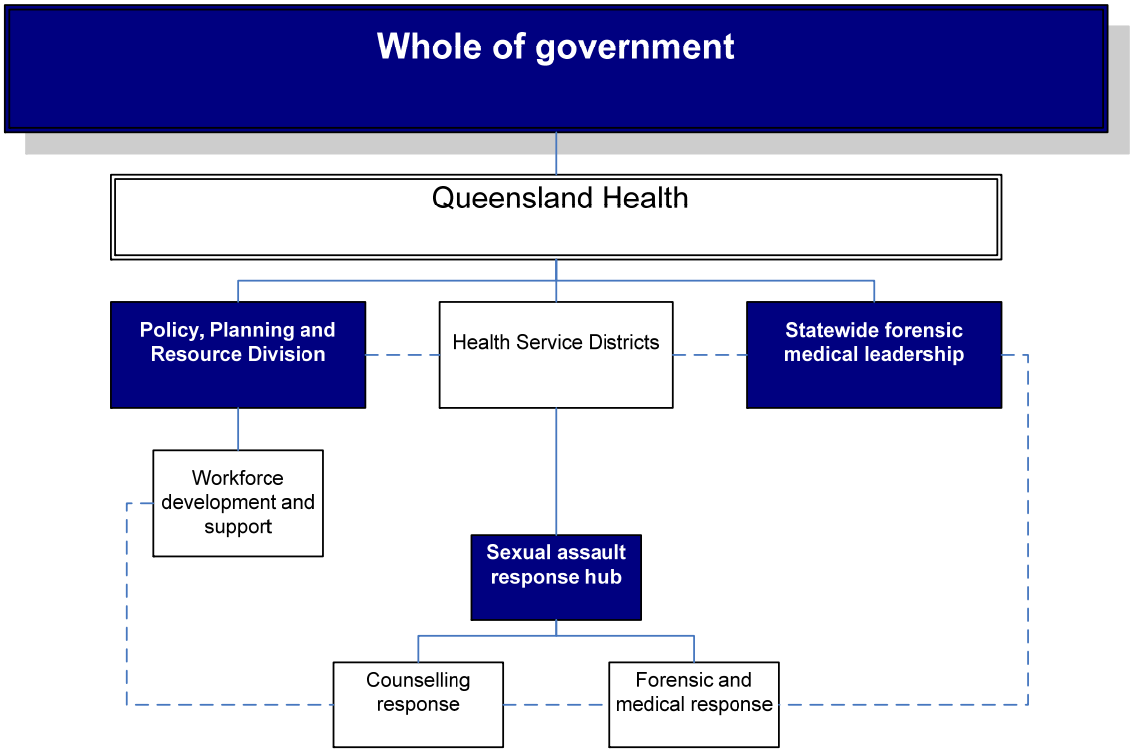
4.1 Introduction

This section presents options for a new approach to delivering health responses to adult victims of sexual assault. The reform options build upon the opportunities for change identified in the preceding section and are consistent with the current evidence base supporting integrated responses for sexual assault.

The new approach relates specifically to Queensland Health responses to adult victims of sexual assault. It is recognised, however, that there are a number of partners involved in delivering a best practice response both within and without the health system. Other service providers who may be involved in a holistic response to adult victims of sexual assault will need to be engaged in further consultation about the proposed changes prior to implementation.

The core components of the new approach outlined in this section are summarised in Figure 1.

Figure 1: Structure of the model of service provision to adult victims of sexual assault



4.2 Overview of model

The new model promotes service provision to all victims of sexual assault through sexual assault response hubs delivered through Health Service Districts. Each Health Service District would be responsible for establishing a hub or hubs and employing staff to undertake core functions such as forensic and medical examinations and counselling and support. Each hub

would be responsible for establishing pathways to police and justice responses. Hubs would provide a response to male and female victims of sexual assault and work with victims of recent and past assaults (consideration may also be given to these hubs providing a response to child victims of sexual assault).

Health Service Districts will be supported in operating the hubs through a strengthened role by Queensland Health central office in relation to quality assurance, workforce development and support and the provision of policy and practice guidance to facilitate 'best practice' service delivery approaches. Queensland Health central office will provide this through a statewide forensic medical leadership function and through establishing capacity in the Policy, Planning and Resourcing (or other appropriate) Division for supporting and developing the counselling and support workforce.

The establishment of sexual assault response hubs in Health Service Districts will deliver a health lead response to victims of sexual assault that includes forensic and medical examinations and counselling and support. Consideration will need to be given to collaboration with police and justice staff as to how and when they will respond to victims. Protocols may be established, for example, whereby police attend at the hub to take an initial statement. Or, if the victim presents to police first, the protocol should then determine that police arrange for the victim to attend at the hub for medical and counselling and support interventions.

Staffing of hubs with medical, nursing and counselling professionals trained in responding to victims of sexual assault would support consistent and high quality service provision and this would be further supported by a statewide forensic medical body and mechanisms coordinating professional development and support for counselling and support staff, as well as by leadership functions within Health Service Districts.

Hubs in each area may look different and would be dependent on the requirements of the community in which they are located. There are some examples of hub models already operating in Queensland, for example at Royal Brisbane Women's Hospital and Toowoomba Base Hospital.

In order to establish a hub or hubs in each Health Service District, Queensland Health central office (in consultation with Health Service Districts) will need to determine the need in each area and associated funding requirements. Consideration will then need to be given to redistributing funds (currently contracted to non-government or Queensland Health based Sexual Assault Services) to Health Service Districts. Tight criteria would need to be attached to these redistributed funds to ensure that service delivery that is purchased or agreed to meets appropriate standards.

Some specialist services may still be required throughout Queensland and these could be purchased from non-government agencies with specific expertise. For example, non-government Aboriginal or multi-cultural services throughout the state may be contracted to provide expert statewide secondary consultation to hubs to support their responses to Aboriginal or CALD clients. However, these services would need to demonstrate they can meet any new service specifications and contractual requirements and are able to provide a statewide secondary consultation and educative support to sexual assault response hubs. Decisions about the need for specialist service provision should be made during implementation planning.

The current 1800 line that operates from 7.00am to midnight could also be maintained to provide links for victims and other service providers to their nearest hub. Ideally, this service should be provided on a 24 hour basis also and could also be delivered through one of the hubs.

All of the above will be supported through cross departmental governance mechanisms and underpinned by statewide assessment and service planning.

4.3 Rationale for new approach

Best practice approaches throughout Australia and internationally bring together all of the services required by victims of sexual assault to enable a one-stop-shop approach to responding. Working with victims of sexual assault requires highly skilled and trained professional staff to address the complex array of post traumatic symptoms that may result. Victims of both past and recent assault require responses that are informed by the same knowledge and skill base. Providing services to men, women and children from the one location establishes a 'hub' of expertise in this area. Service provision from the one location also provides an accessible and clear entry point for all victims of sexual assault regardless of when the assault occurs.

The following sections describe each aspect of the new approach in terms of proposed changes to the:

- service system, which comprises the legislative and policy context; governance mechanisms; needs assessment and service planning; and quality management, including performance management and capacity building; and

- service response, which includes the service delivery and operational models.

4.4 Options for service system reform

The following section outlines options for reform at a service system level. This includes consideration of a whole of government approach to responding to sexual assault and the role of Queensland Health in promoting service delivery that is evidence based and quality assured.

4.4.1 Whole of government policy and planning

There is international evidence that the impact of sexual assault on the community is profound and far reaching and that the consequences of sexual assault require a holistic response from a range of services. An integrated approach to sexual assault provides a comprehensive response to victims across multiple services. Establishing an integrated response must begin at a whole of government level in order to effectively drive practice change at the service delivery level.

There is currently limited cross government collaboration in Queensland in relation to responses to adult or child victims of sexual assault or in relation to programs for sexual assault offenders / perpetrators. There is also limited interplay between policy makers governing responses to victims of family violence and sexual assault.

The following government stakeholders are involved in responding to victims and perpetrators of sexual assault:

- Queensland Police;
- Justice and Attorney General's Department;
- Department of Communities;
- Department of Corrections;
- Department of Child Safety;
- Department of Education;
- Department of Emergency Services; and
- Queensland Health (including representatives from disability, mental health and drug and alcohol).

A whole of government approach is required that relies on inter-departmental communication in relation to policy development, workforce development and practice improvements.

A number of mechanisms could be established to facilitate such communication, including in the following areas:

- a Sexual Assault Executive Committee to oversee service system reform – this could consist of the most senior representatives across the government departments identified above, ideally at a Director-General level;
- a Senior Officer's Group of representatives from the above named departments could further develop initiatives and recommendations arising from the executive committee; and
- a secretariat group, possibly from the Policy, Planning and Resourcing Division of Queensland Health could coordinate the above two groups and action decisions taken in both the Sexual Assault Executive Committee and Senior Officer's Group.

It is understood however that the Queensland Government has moved away from discrete Executive Committees and maintains just one within Human Services. If establishing a discrete mechanism (as recommended above) is contrary to government policy, other means should be considered to facilitate cross government communication.

The purpose of cross government communication is to promote:

- a statewide focus on prevention and community education in relation to sexual violence;
- integrated policy development;

- development and management of whole of government reporting frameworks; and
- communication protocols and role clarification.

Each of these elements are discussed below.

Statewide focus on prevention and community education

A statewide focus on prevention and community education could be driven from a whole of government perspective involving education, police, health and community based initiatives. This focus could include recent assaults, childhood abuse and abuse of males. Consideration could also be given to the relationship between sexual assault and family violence as has occurred in Victoria.

Integrated policy development

The Interagency Guidelines introduced in 2002 currently inform responses to sexual assault in Queensland. These guidelines should be redeveloped in line with reforms and greater efforts made to implement these across the state. Policy developed across other programs and departments (including police and justice and Child Safety) should be reviewed to ensure they are consistent.

Development of a unified sexual assault policy framework would ensure:

- a whole of government approach to service provision for adult (and child) victims of sexual assault;
- a focus on responses to males, including male victims of childhood abuse and those in prison populations;
- a focus on the needs of Indigenous communities and other victim sub-groups; and
- consistency with other relevant government policies (for example, family violence).

Whole of government reporting frameworks

The introduction of a whole of government reporting framework in relation to sexual assault would allow the government to monitor and track numbers of victims and services received across Queensland. Data collection should be underpinned by strong reporting requirements driven by individual Health Service Districts. Monitoring and reporting requirements could also be established for police, courts and offender programs.

Communication protocols and role clarification

High level agreement on the roles of each service provider and the relationships between each service provider would support integrated service delivery at a local level. Consideration could be given to redeveloping and implementing the Interagency Guidelines which provide direction in relation to roles, responsibilities and communication. A comprehensive implementation strategy should be developed at a whole of government level to drive this change.

Ongoing communication at a senior level would ensure that any problems with implementation of revised practice guidelines are reported on and addressed at an early opportunity.

4.4.2 Leadership role of Queensland Health central office

The new approach requires Queensland Health central office to play an enhanced leadership role in relation to responses to adult victims of sexual assault could be enhanced in order to facilitate and promote best practice responses. This would ensure that:

- strong leadership is in place to support the whole of government approach outlined above;
- policies and practice guidance are developed that are underpinned by evidence and are consistent with other government policy directions;
- policies and practice guidance are implemented appropriately throughout Health Service Districts;
- funding of Health Service Districts to respond to victims of sexual assault through hubs is evidence based and demand driven and is able to meet the needs of victims throughout Queensland 24 hours a day; and
- practice standards, data collection and monitoring and reporting mechanisms are in place.

Queensland Health central office could consider building internal capacity in order to undertake more effective leadership in relation to the issues outlined above. The following functions could be undertaken by Queensland Health central office, either through the Policy, Planning and Resourcing Division, or other group identified within the Department:[131]

- collaboration with other government departments;
- needs assessment and service planning;
- quality management, including quality assurance, performance monitoring and reporting, continuous improvement and capacity building; and
- stakeholder engagement and management.

[131] KPMG did not review sections of Queensland Health central office to determine where functions should be undertaken. This should be considered as part of implementation planning

Each of these functions are discussed further below.

Collaboration with other government departments

The need for cross government collaboration and communication was outlined in the preceding section. Queensland Health could take a lead role in establishing this communication mechanism and this could occur through a team of staff able to develop and implement policy and practice advice arising from this group (the secretariat function).

Needs assessment and service planning

In order for responses to victims of sexual assault to be consistent with best practice evidence, there is a need for responses to:

- be available statewide, on a 24 hour basis and provide a crisis response to men and women (and children); and
- provide follow up care post a crisis response and evidence based therapeutic interventions with survivors of childhood sexual abuse.

There is a current opportunity, prior to the next SASPP contract period, for Queensland Health to:

- determine the need for services for victims of sexual assault on a location by location basis according to population and community characteristics;
- determine appropriate funding allocations to ensure that counselling and forensic medical services are available 24 hours a day to respond to victims in crisis after recent assault;
- determine funding arrangements based on short, medium and long term therapeutic interventions with victims of sexual assault; and
- provide funding to Health Service Districts for service provision (through hubs) on that basis.

Purchasing sexual assault services

Integrated responses to victims of sexual assault require cooperation and coordination from counsellors, medical and nursing practitioners and law enforcement representatives. The non-government Sexual Assault Services have, to this point, not sufficiently engaged with these other components of the response (police and medical and nursing practitioners) resulting, in many areas, in a fragmented service system with little coordination. Sexual Assault Services based within Health Service Districts appear to have more successfully engaged with their service system partners.

Ideally, in the short term (prior to the introduction of hubs), Queensland Health's purchasing of sexual assault services from the non-government sector in 2009 must be consistent with the guidance provided in the Queensland Government's *Framework for Investment in Human Services.* Contracts should be based on detailed service specifications and should also specify that service provision must:

- be available to men and women (and children if considered appropriate after consultation at a statewide level with Department of Child Safety);
- be evidence based and meet practice standards (to be developed);
- be available to victims along the continuum from point of crisis after a recent assault through to therapeutic responses to adult survivors of childhood sexual abuse;
- include common approaches to intake, assessment and case planning that consider victim needs for short, medium or long term therapeutic intervention; and
- be reported on in relation to key performance indicators that demonstrate timely and effective service responses.

These considerations should also inform funding arrangements with Health Service Districts for the establishment of sexual assault response hubs at a later point in time.

If Queensland Health accepts the proposed model outlined in this report, it follows that consideration should be given to how best to use the available and limited government funds for sexual assault victims in the state. This may mean that funding currently provided to non-government Sexual Assault Services should be redirected to the sexual assault response hubs to be established in each Health Service District.

There may be some argument to continue funding some of these specialist non-government services, particularly those that are specialist providers to Indigenous or CALD communities. However, these services would need to demonstrate they can meet any new service specifications and contractual requirements and are able to provide a statewide secondary consultation and educative support to sexual assault response hubs. Decisions about the need for specialist service provision should be made during implementation planning.

Quality processes

Queensland Health central office should develop and implement a range of quality management measures for sexual assault response hubs and any specialist funded non-government services. This should include key performance indicators, practice standards (that include an annual cycle of self assessment and a three yearly external assessment process), and data collection and monitoring activities to underpin this.[132]

[132] Data collection methods are already in place across non-government and health based Sexual Assault Services. This mechanism may be able to be expanded upon to provide a data collection facility suitable for the sexual assault response hubs

Practice standards should be developed that cover service provision by hubs, such as:

- forensic medical response;
- counselling intervention and support at the point of crisis;
- victim access to follow up counselling and support; and
- medium to longer term therapeutic clinical interventions with victims of sexual assault.

Practice standards, once developed or endorsed by Queensland Health central office, would be implemented by each Health Service District. Monitoring of the sexual assault response hubs performance against the standards could be as follows:

- via annual organisational self assessment;
- through the provision of quarterly reporting to Health Service Districts and then to Queensland Health central office; and
- through three yearly external evaluation of the service against the standards.

Current data collection mechanisms do not adequately reflect the nature of sexual assault (reported) in Queensland or the extent of the response provided. The development of a specific data collection and monitoring framework would enable Queensland Health to make informed decisions in relation to funding and contractual arrangements. Such a framework should include:

- appropriate data sets (that provide information about victim profiles and interventions used) to be reported on by funded services; and
- key performance indicators that are reported against quarterly.

Data obtained by Queensland Health central office should then be reported back to sexual assault response hubs in a meaningful way that allows them to understand their performance in relation to other areas. This information should also be shared with service system partners such as the statewide forensic medical body and police.

Stakeholder engagement and management

To support service system reform Queensland Health central office should actively engage with sexual assault response hubs or non-government services funded to provide specialist sexual assault responses. Queensland Health central office should consider establishing a communication mechanism with sexual assault response hubs and Health Service Districts to support collaborative implementation of changes and ongoing service system management. Engaging service providers through a regular communication mechanism could involve:

- quarterly meetings of all sexual assault staff representatives (funding arrangements would need to be inclusive of this requirement to ensure that rural service providers are able to attend);

- regular email communication about policy/practice/workforce development initiatives; and

- active participation of sexual assault response hubs in decision making about program delivery and program planning.

Any such group convened to enhance the engagement of staff in sexual assault response hubs would need agreed terms of reference and communication structures.

Queensland Health central office could also actively engage service provider representatives at a senior level from the range of partners involved in providing a response to adult victims of sexual assault, including police, medical and nursing practitioners, counsellors and justice staff.

4.4.3 Statewide forensic medical leadership[133]

The CFMU currently provides leadership in relation to the provision of forensic medical services in Queensland and a Statewide Clinical Protocol and Clinical Governance processes are already reportedly in place to support the provision of forensic medicine throughout Queensland. However, direct service provision through the CFMU is limited to a small number of locations and its statewide focus is restricted by capacity. An enhanced leadership function in relation to forensic medical service delivery to victims of sexual assault will underpin and support consistent service provision by medical and nursing practitioners who are trained, supported and work as part of a team that responds to victims of sexual assault (in sexual assault response hubs).

Service provision currently occurs differently throughout the state with some victims receiving a medical examination from an FMO, while others are reliant on GMOs. There are inconsistent practices in relation to whether a victim can access an examination without early involvement of police. Clarification is also required about the use of FNEs, particularly through liaison with Queensland Police and the criminal justice system. It is important that capacity is built within a statewide forensic medical body to play a lead role in policy development governing service provision, and provide clinical governance for FMOs, FNEs and other medical practitioners undertaking examinations through sexual assault response hubs.

Statewide forensic medical leadership should provide professional oversight of forensic medical responses to adult (and child) victims of sexual assault across Queensland. Such a role should be medically driven and include liaison with stakeholders involved in the provision of a forensic medical response such as forensic laboratories, police and prosecution staff.

The leadership role should be situated within Queensland Health central office and functions should include:

[133] The role of the Clinical Forensic Medicine Unit was not reviewed in detail as part of this project. Some or many of the functions described in this section may already be undertaken by the unit.

- the provision of clinical governance of forensic medical services within Queensland;
- management of the accreditation scheme for medical and nursing practitioners that includes ongoing and compulsory training requirements;
- determining practice approaches for responding to victims of sexual assault (for example use of video, photography, colposcopes);
- use of statewide practice standards and quality assurance mechanisms including feedback loops; and
- provision of expert advice and peer support to accredited medical and nursing practitioners employed by Health Service Districts.

Each of these functions is discussed further below.

Clinical governance of forensic medical services

The clinical governance function should involve overseeing the provision of forensic medical responses to adult (and possibly child) victims of recent sexual assault in Queensland. This would include the development and implementation of practice approaches and standards (discussed further below) and monitoring service provision (also discussed below). Other responsibilities may include accreditation of medical and nursing staff to conduct forensic examinations, and liaison with other bodies to gain feedback about the quality of responses provided (for example, forensic laboratories, police and prosecution staff).

Liaison should also occur with police, Queensland Health central office and Health Service Districts about appropriate remuneration for medical and nursing practitioners who are on call or available 24 hours a day. Appropriate consideration is also required of the financial and clinical support needs of medical and nursing practitioners preparing court reports or involved in providing testimony to courts.

Other governance roles should include:

- liaison with Health Service Districts and sexual assault response hubs in relation to best practice approaches;
- the development of practice standards to inform forensic medical service delivery;
- establishing links with the workforce development and support mechanism or with medical colleges and universities; and
- liaison with Indigenous communities to collaboratively develop approaches to support this vulnerable population to access forensic and medical support post a sexual assault.

Accreditation and training requirements

The statewide forensic medical leadership body should also be responsible for determining minimum training requirements (or competencies) of staff undertaking forensic examinations and for making such training as is required available to medical and nursing practitioners. This may involve liaison with universities (including the Victorian Institute for Forensic Medicine through Monash University) or other professional training bodies (such as the Centre for Excellence in Sexual Assault). If possible, joint training opportunities should be offered to medical and nursing practitioners with other components of the sexual assault response.

Introduction of minimum training requirements or competencies could be formalised through an accreditation process that ensures all practitioners are suitably qualified to conduct examinations. Accreditation may also encourage police to access FNEs in sexual assault cases and increase their credibility in court.

Practice approaches

For Queensland to provide best practice responses to adults that have been sexually assaulted, victims should be able to access a forensic medical examination in the absence of police involvement in the first instance. Considerable feedback was received from stakeholders throughout the review that forensic medical examinations should be available to victims whether police are involved in the first instance or not. Many other jurisdictions throughout Australia provide this option (see Appendix B). Practice guidance in relation to this (particularly in relation to time limited storage of forensic specimens) should be developed by the forensic medical leadership body in consultation with Queensland Health central office, medical and nursing practitioners, forensic analytical body, Queensland Police and the Office of the Director of Public Prosecutions.

Ongoing decisions may also need to be made about practice approaches, particularly as new technologies emerge. These decisions should be made by the statewide forensic medical body in consultation with relevant stakeholders such as police and the Office of the Director of Public Prosecutions.

Practice leadership could also be demonstrated through ongoing connections to tertiary institutions and regular monitoring of national and international forensic medicine research and literature.

Practice standards and quality assurance mechanisms

Appropriate standards and quality assurance mechanisms should be in place to ensure forensic medical examinations are of a high standard. This should involve a reporting mechanism between Health Service Districts and the statewide forensic medical leadership body that report on key performance indicators relating to the forensic medical service. Liaison should also occur between the forensic medical leadership body and the police and forensic analytical laboratories to review the quality of evidence collected.

Mechanisms should also be put in place to obtain feedback from victims of sexual assault about the examination process and outcomes.

Feedback from the above should inform further practice directions provided to forensic medical and nursing practitioners and form part of any ongoing training provided.

Expert advice and peer support

The statewide forensic medical body could provide medical and nursing practitioners with expert advice and peer support in relation to their role. This advice and support should include:

- group or peer supervision;
- mentoring by senior staff with extensive experience in conducting examinations;
- assistance with preparing for court; and
- debriefing and support during and after challenging forensic and medical examinations.

4.4.4 Workforce development and support

There is currently no centralised body with responsibility for the professional development of the sexual assault counselling and support workforce.

A number of issues have emerged in relation to the professional development of the sexual assault workforce, including:

- Sexual Assault Services staff have limited access to training and professional development opportunities;
- there are a variety of approaches to working with and responding to victims of sexual assault; and
- individual services are creating separate policy approaches and practice guidelines to guide agency responses to victims.

There is also no endorsed therapeutic intervention framework in which therapists and counsellors practice. As a result, a number of Sexual Assault Services throughout Queensland have developed their own range of materials to guide practice but this has resulted in multiple endeavours to achieve the same outcome. There is currently no formal mechanism through which this information can be shared. Services have also developed their own individual processes for intake, assessment, intervention planning and case management, and have developed their own promotional materials.

Under the proposed new model, counselling and support staff will be located within sexual assault response hubs within Health Service Districts. The counselling and support workforce should already possess a minimum tertiary level qualification in social work, psychology or counselling (or equivalent). Professional development for this group should be specifically targeted at sexual abuse and interventions to address the consequences of this type of trauma.

A mechanism should be established by Queensland Health central office that provides practice leadership and support to enhance statewide responses to adult (and child) victims of sexual assault. Such a mechanism could be a located within Queensland Health central office or sit separately, for example, in a university, hospital or high performing sexual assault hub specifically funded for the purpose. The benefits of each of these options are as follows:

- locating the mechanism within Queensland Health central office is cost effective. Central office could play a lead role in the development of a range of materials to support practice in sexual assault response hubs including practice standards;

- locating the mechanism within a university would give it a strong academic and research focus, but outputs may not be particularly practical or practice focused;

- locating the mechanism within a hospital would create the opposite challenge whereby outputs may be practice focused but lack the academic rigour; and

- funding a high performing sexual assault hub to undertake the role would require transparent selection and purchasing processes to ensure that other hubs are not alienated.

Regardless of the location of the mechanism, strong links should be established with hospitals, universities, Queensland Health central office and sexual assault service providers (hubs) to ensure success.

A mechanism to support the professional development of the sexual assault counselling and support workforce could also be responsible for a comprehensive professional development framework for other services involved in responses to victims of sexual assault, including police and court staff.

There is also an opportunity to create a range of therapeutic guidelines determining best practice therapeutic approaches for use with victims. Clinical support could be provided to counselling staff working with victims of sexual assault in a therapeutic and support capacity (in a similar way to how the statewide forensic medical body provides support for medical and nursing practitioners).

The relationship between the forensic medical leadership body and the workforce development and support mechanism should be discussed and refined with stakeholders during the next phase of consultations for this project.

Functions of a workforce, development and support mechanism could include:

- practice leadership through the development of a range of materials to support evidence based best practice by services responding to victims of sexual assault;

- the development and delivery of training as per a professional development framework for sexual assault services, police, court staff, and other relevant professional groups;

- provision of policy advice to Queensland Health central office; and

- research in relation to sexual assault.

Each of these are discussed below.

Practice leadership

A range of practice tools to support evidence based best practice responses to adult (and child) victims of sexual assault could be developed. These practice tools could include:

- a common assessment and planning framework to guide assessment and intervention with victims of sexual assault – the implementation of common tools would ensure that practice approaches become more uniform across the state and that victims would receive a similar service (albeit victim centred) where ever they present in Queensland; and

- guidelines in relation to appropriate therapeutic responses to victims of sexual assault – these interventions should be evidence based and designed to ameliorate the negative effects of sexual assault. Interventions with victims should be either short, medium or long term depending on the assessment.

Any tools developed should consider the different presentations of victims of recent and historical assault as assessment and planning approaches may differ somewhat in focus. For example, assessment of a recent victim of assault will focus on determining current presentation and support needs including access to forensic and medical care and police intervention. This assessment will also focus on immediate safety needs. Assessment of survivors of historical assault will focus on the impact of the assault on the whole of life of the victim. Planning for historical survivors may include greater liaison with associated service providers such as general practitioners. Interventions will focus on addressing trauma related symptoms and consequences.

A practice framework should also be developed that steps out guidance in relation to assessment and interventions that are appropriate for short, medium and long term work. Interventions considered by the workforce development and support mechanism would include evidence based cognitive therapies and any other effective intervention that is supported by research. The mechanism could then provide training to Sexual Assault Services in relation to new therapeutic approaches.

The use of the above practice tools and practice guidance should be built into Queensland Health's central office funding arrangements with Health Service Districts and sexual assault response hubs.

Professional development

A professional development framework to guide the training and learning needs of the counselling and support sexual assault workforce would ensure consistent skill sets amongst practitioners, resulting in more uniform service delivery. A professional development frameworks should include:

- minimum qualifications and experience of staff providing therapeutic interventions with victims of sexual assault (as already discussed); and

- minimum training requirements to enable staff to work within this practice paradigm.

The primary aim of this approach would be to ensure that counselling and support staff are current in their understanding of appropriate responses to victims of sexual assault. The workforce development and support mechanism would liaise with Queensland Police, the statewide forensic medical body and the Office of the Director of Public Prosecutions to identify and promote joint training programs and opportunities.

Policy advice to Queensland Health central office

The workforce development and support mechanism would maintain expertise in relation to responses to victims of sexual assault. As a consequence of this, it should play a lead role in providing Queensland Health central office with advice about policy and practice directions.

Sexual assault research

It would be important that ongoing relationships are established with universities and hospitals in relation to the latest research and emerging practice issues in responding to victims of sexual assault. It could also be anticipated that the professional development and support mechanism would develop and maintain relationships with other jurisdictions within Australia to maintain currency in relation to policy and practice directions. Development of research or academic papers for presentation at conferences would also be appropriate. Regular communication channels should be established with sexual assault services to inform them about developments in research or changes to evidence about appropriate interventions.

4.5 Options for improving the service delivery response

This section outlines options for reform at a service delivery level that are consistent with international best practice responses focusing on integrated or co-located service provision to victims of sexual assault.

It is proposed that the service response be significantly enhanced through implementing a new service delivery model of integrated 24 hour sexual assault response hubs in each Health Service District.

This proposal is outlined in detail in the following sections.

4.5.1 Leadership by Health Service Districts

Recent changes to the structure of Queensland Health mean that there are now 15 Health Service Districts. It is important that each Health Service District is able to provide a sexual

assault coordination and leadership function to oversee responses to victims of sexual assault through sexual assault response hubs.

Health Service Districts currently have different approaches to responding to victims of sexual assault. Some emergency departments respond appropriately to victims while others do not see this as their core business. In many cases, the responsibility of coordinating a response is left to police. While Interagency Guidelines were distributed to Health Service Districts, there appears to have been little effort to implement them.

For best practice responses to victims of sexual assault to be available across Queensland, Health Service Districts will be required to provide leadership in establishing and managing the proposed sexual assault response hubs. It is proposed that a senior executive in each Health Service District hold the sexual assault portfolio and be responsible for planning and establishing the hubs and for ongoing management and reporting.

4.5.2 Sexual assault response hubs

The review of international literature and the evidence collected as part of the stakeholder consultations for this review indicates that best practice models of service delivery to victims of sexual assault:

- are coordinated and victim centred and allows victims control over the pace and nature of the response;
- are accessible and visible and has clear entry points for victims following recent assault and for victims who have experienced historical or childhood abuse;
- provide all the services victims require after a recent assault from the one location;
- are delivered by professionals from health, counselling and criminal justice disciplines with extensive training in, and understanding of, the nature and impact of sexual assault; and
- are responsive to the needs of victims from disadvantaged or minority groups.

Responses to victims of sexual assault in Queensland are currently ad hoc and do not provide visible or accessible entry points in many areas of the state. Service provision may or may not be coordinated and non-government Sexual Assault services appear to have limited involvement in crisis responses, focusing more on the provision of support to survivors.

Reforms are required to expand the availability of crisis services to recent victims of sexual assault and establish a flexible approach to responding to survivors of sexual assault.

Establishing a sexual assault response hub or hubs in selected locations throughout Queensland would create a ‘hub’ of expertise in responding to sexual assault and would ensure that victims needs across a range of disciplines (health, wellbeing and criminal justice where appropriate) can be met.

Sexual assault response hubs should provide an environment that is appropriate to respond to victims according to evidence based best practice and would promote collaborative relationships between medical, nursing, counselling staff and police.

Sexual assault response hubs could have the following functions:

- employment of medical or nursing practitioners on a full or part time basis to cover day time forensic medical examinations;
- liaison with emergency departments in relation to victims who may require urgent medical care;
- ensuring availability of medical or nursing practitioners on rosters to provide an after hours forensic medical response;
- employment of staff on a full time basis to provide counselling and support to victims following recent assault, or to survivors of historical abuse;
- ensuring availability of counsellors and support staff on rosters to provide an after hours response.

Other functions of the hubs should include:

- provision of clinical support to medical or nursing practitioners in rural or remote areas who are conducting forensic medical examinations after hours (in approved locations); and
- provision of support to counselling and support staff in rural or remote areas who are providing a response.

Sexual assault response hubs could also provide responses to child victims of sexual assault or abuse.

Staffing of hubs with medical, nursing and counselling professionals trained in responding to victims of sexual assault would support consistent and high quality service provision, and this would be further supported by the statewide forensic medical body and the mechanism coordinating professional development and support for counselling and support staff, as well as by the leadership function within the relevant Health Service District.

Hubs in each area may look different and would be dependent on the requirements of the community in which they are located. There are some examples of hub models already operating in Queensland, for example at Royal Brisbane Women's Hospital[134] and Toowoomba Base Hospital.

Hub locations would need to be determined by each Health Service District but would need, at a minimum, to include:

[134] Although Royal Brisbane Women's Hospital was not consulted with as part of this review, many services identified the facilities and response there as 'best practice'

- 24 hour and hospital emergency department access if necessary;
- medical facilities (including a room) and equipment to facilitate forensic examinations and storage of forensic specimens; and
- counselling rooms.

Hubs would be expected to participate in quality assurance processes and data collection requirements and regular reporting to Queensland Health central office through Health Service Districts.

Each Health Service District would need to establish minimum requirements for a sexual assault response hub, but bottom line service provision would involve the 24 hour availability of a medical / nursing practitioner and a counselling / support staff member.

The current 1800 line that operates from 7-00 am to midnight could be maintained to provide links for victims and other service providers to their nearest hub. Ideally, this service should be provided on a 24 hour basis also and could also be delivered through one of the hubs.

Crisis response

Both male and female victims who have experienced a recent sexual assault could present at sexual assault response hubs.[135] They may present themselves directly to the hub, or may be directed/taken to the hub by police or a counsellor (or other service in the community such as a general practitioner or from a government facility such as a prison). Once at the hub, the following functions would occur:

- the victim is assessed for injuries and emotional presentation and both injuries and safety concerns would be addressed;
- the victim receives information about the responses available (forensic medical examination, counsellor lead support and the police response) and services are provided accordingly;
- the medical or nursing practitioner explains the purpose and process of the examination and would undertake this after receiving the victim's consent;[136]
- the medical or nursing practitioner discusses medical follow up requirements with the victim and make appropriate arrangements for these;
- police may or may not attend to provide a criminal justice response depending on the victim's choice;

[135] Hubs may be specific locations where all services are co-located, or maybe a place from which responses are delivered.
[136] A determination will need to be made by Queensland Health, in consultation with the statewide forensic medical body, as to whether forensic medical examinations can occur without police involvement.

- the counsellor or support person addresses safety issues with the victim and ensures safety upon discharge;

- the counsellor undertakes an assessment of the victim's presentation and ongoing support needs (using an assessment tool common to all locations);

- the counsellor coordinates discharge and would arrange follow up counselling and support responses according to the level of need determined by assessment;

- the counsellor also coordinates medical and police follow up if appropriate and provision of support for victims going through legal court cases would also be provided.

Not all victims would be able to access hubs (due to remoteness of their location or lack of transport arrangements). In these instances, the sexual assault hub could still coordinate the response to victims, using qualified and accredited medical or nursing practitioners and counsellors situated in areas nearest to the victim. Hub staff should also provide telephone or video link support to staff providing the remote response.

The following case study provides an example of how a response to a recent victim of sexual assault may occur using a hub model.

Case Study one – hub response to recent assault

Janine is 19 years old and has been raped at a party on a Saturday night. Not knowing where else to go, Janine presents at the nearest hospital emergency department. On arrival, Janine is triaged and provided with information about the options for a response. Janine decides she would like to be examined and talk to a counsellor and maybe the police. The hospital she has presented at is not a sexual assault response hub. However, as per the protocol in place between the hub and other hospitals, the following occurs. A nurse from the emergency department contacts the hub 'on call' practitioner (could be either a counsellor or nursing team member). The hub practitioner talks to Janine and ascertains that she would like to proceed with a forensic examination and to talk to police. The hub facilitates Janine's transportation to their premises.

Once at the hub, Janine is again assessed in relation to her presentation. Both the counsellor and the FNE are present and do this together. Arrangements are made for the police to attend. A brief history of the assault is taken from Janine with the counsellor, nurse and police present. Janine then consents to the forensic medical examination and this occurs at the hub. The police talk to Janine for some time and take a preliminary statement. The counsellor arranges for Janine to come back to the hub the following week for review.

At the follow up, Janine is seen by the same counsellor and nurse for medical and psychological review. The counsellor makes an assessment (using common assessment tools) of Janine's presentation and together, she and Janine determine appropriate support needs. Janine continues to see the counsellor for some weeks until she feels able to reduce attendance at the hub. She knows she has the option of returning for support should her case proceed to court.

Survivor response

Adults who have experienced past or childhood assault could be referred to a sexual assault response hub in a variety of ways, including through the police, general practitioner, mental health or drug and alcohol service, community health, or through a facility where they may be incarcerated (prison) or receiving treatment (mental health facility). Referral arrangements should be in place between these services and the sexual assault response hub.

Once at the sexual assault response hub, the following would occur:

- assessment by the counsellor of presenting needs;
- liaison with medical or nursing practitioner if sexual health or other health issues are apparent;
- liaison with other professionals if appropriate (for example mental health professional, general practitioner);
- completion of assessment and development of therapeutic plan in consultation with the victim; and
- implementation of therapeutic plan.

Queensland Health central office (or the mechanism responsible for professional development and support for counselling and support staff) would develop the assessment and intervention planning tools and their use could be made mandatory in all sexual assault response hubs. The use of common assessment and planning tools would promote the use of evidence based best practice approaches throughout the system.

A client intervention plan would consider such things as referrals and liaison to other services, case management needs and treatment modes for use in therapeutic intervention. It would also determine whether short term, medium term or long term intervention is required.[137] Provision of support for victims going through legal court cases could also be provided.

The following case study provides an example of how a response to a survivor of sexual assault or childhood abuse may occur using a hub model.

Case Study two – hub response to historical abuse

Claudia migrated to Australia when she was 7 years old with her parents. Prior to leaving her country of origin, Claudia was sexually abused for months by her uncle. Now having a child of her own, Claudia is struggling to manage the flashbacks and panic attacks that she thinks are related to the abuse. Claudia makes an appointment to talk to her general practitioner about her concerns and is referred to the sexual assault response hub. Once at the hub, Claudia is assessed using the common assessment tool and together with the counsellor, agrees to an intervention plan that is of short term duration. The plan involves a therapeutic

[137] Definitions and practice guidance around short, medium and long term intervention would be developed by Queensland Health in consultation with the workforce development and support mechanism.

pathway to address the symptoms that have been triggered by her pregnancy. The counsellor talks about liaising with Claudia's general practitioner in relation to the intervention and Claudia indicates she is comfortable about this. At the conclusion of the therapeutic process, Claudia is equipped with a range of coping strategies and understands that she can come back to the hub for support at any point in time.

Counselling and support staff assigned to sexual assault response hubs may provide outreach to rural or remote communities on a rostered basis to undertake medium or longer term counselling with victims of past or historical sexual assault. They may also facilitate active referrals to services in areas closer to the victim's home and provide secondary consultation to local accredited counsellors.

Hub linkages

Sexual assault response hubs would be expected to maintain strong linkages with service system partners including police, staff from the Office of the Director of Public Prosecutions and other health and community based services. Local protocols would need to be in place with a range of partners to facilitate appropriate referrals and ongoing communication.

Responses provided by all staff located in hubs must be appropriate to victims from population sub-groups and hubs should demonstrate cultural competence in responding to Indigenous clients. Secondary consultation could be obtained from culturally specific organisations or from services with particular expertise in other presenting issues (such as disability). The use of Indigenous liaison staff should also be considered.

Workforce requirements

The role of forensic medical and nursing practitioners is to:

- conduct examinations according to their skill level (this would be determined through the accreditation process undertaken by the statewide forensic medical body); and
- prepare for and attend court as appropriate.

Medical and nursing practitioners could either be employed through the hub to respond during business hours or participate on an after hours roster (if employed by the hub during business hours they could also provide follow up medical care to victims of recent assault).

The statewide forensic medical leadership body, in conjunction with Health Service Districts, should be responsible for ensuring that forensic medical or nursing practitioners maintain currency in terms of professional knowledge and receive appropriate peer support and professional development opportunities.

Counsellors and support staff should be employed through the hub to respond during business hours or participate on after hours or rural remote rosters.

Responses to victims of recent or past sexual assault require similar responses in that they all require assessment, planning and intervention considerations. Counselling and support staff should be able to respond to both groups and functions could include undertaking assessments of victims of sexual assault (for both crisis and survivor presentations), and, in consultation with the victim, developing an appropriate intervention plan and liaising with other services as appropriate to implement plan.

Counsellors should have an appropriate tertiary qualification and be supported in their role through the Health Service District and professional development and support mechanism. The workforce development and support mechanism may, in consultation with Queensland Health central office, determine appropriate training and professional development opportunities to ensure that the skills and knowledge of counsellors remains current.

4.5.3 Implementation of the sexual assault hubs

The Health Service Districts should lead the establishment of an integrated sexual assault service hub in their area. This could involve the following activities:

- identification of an appropriate 24 hour response location (or sexual assault response hub) in each district;
- establishing linkages between the hub site and other service points;
- the staffing of a 24 hour hub by trained counsellors and/or forensic medical or nursing practitioners;[138]
- identification of pathways for clients experiencing recent assault or historical abuse (and promotion of these locally); and
- implementation of policy and practice guidance developed by Queensland Health central office.

Identification of the service hubs

Each Health Service District should promote service provision through clearly identified sexual assault response hubs (hubs). These hubs need to have 24 hour access and should probably be located in or near to a hospital emergency department. Any locations selected as a hub need to have facilities that are consistent with best practice evidence, and include:

- an appropriate physical environment;
- an appropriate emotional environment; and

[138] The staffing levels for each hub would need to be determined based on local planning processes to be undertaken to inform implementation

- appropriate equipment.

While at least one location in each Health Service District should be identified to act as a hub, other locations may also be accredited to provide a response to victims throughout business hours or after hours. These locations should also have facilities and an environment consistent with best practice evidence.

Identification of the hub location would involve:

- analysis of Health Service District characteristics including population, geographical environment and any community factors contributing to a demand for service (such as the case on the Gold Coast with schoolies week); and

- determining staffing requirements to ensure 24 hour availability of medical or nursing practitioners and counselling staff.

Linkages between the hub and other service points

Establishment of a hub response model in each Health Service District would require liaison and communication with a number of stakeholders, including:

- hospital staff, particularly emergency departments at hospitals identified as potential hub locations;

- staff from other hospitals within the Health Service District;

- Indigenous communities;

- local police representatives; and

- other services in the area providing a response to victims of sexual assault.

It will be important for Queensland Health to ensure that the purchasing of other specialist sexual assault services in each District strongly support and complement the functioning of the integrated service hub. This should include:

- selecting providers that offer services that complement the activities of the service hub and are targeted to un-met service need in the area, for example services for high needs or vulnerable groups that face barriers to accessing mainstream services (such as Indigenous and CALD communities); and

- including contractual requirements that require service providers to work in partnership with the service hub and meet relevant practice standards and procedural requirements.

Staffing a 24 hour hub

Sexual assault response hubs would require the following staff, available throughout a 24 hour time period:

- forensic medical or nursing practitioner; and
- counselling and support staff.

Each Health Service District would need to ensure that there are appropriate staffing arrangements in place (including adequate rosters to cover after hours presentations) to respond to victims presenting post a recent assault. Medical and nursing practitioners should be accredited (by the statewide forensic medical body) to undertaken examinations and appropriately remunerated to undertake examinations, prepare court reports and attend court to provide evidence. Counselling staff must have a tertiary qualification and an understanding of the nature and consequences of sexual assault and be trained to provide a response to victims who have undergone recent and past assaults. Interventions used by the counsellor must be evidence based and as per guidance from the workforce development and support mechanism.

The use of nurses employed full time in sexual assault response hubs may solve any difficulties in relation to obtaining medical practitioners to conduct forensic examinations. FNEs have been proven to work effectively with counselling staff in other jurisdictions and are a cost effective way of providing business hours coverage. Support could be provided to FNEs through the leadership function within the Health Service District and through the statewide forensic medical leadership body.

In regional and remote areas, another option is that women's sexual health nursing and medical practitioners hold a dual role and also hold accreditation to undertaken forensic medical examinations.

These approaches should be considered through further consultation and planning processes prior to implementation.

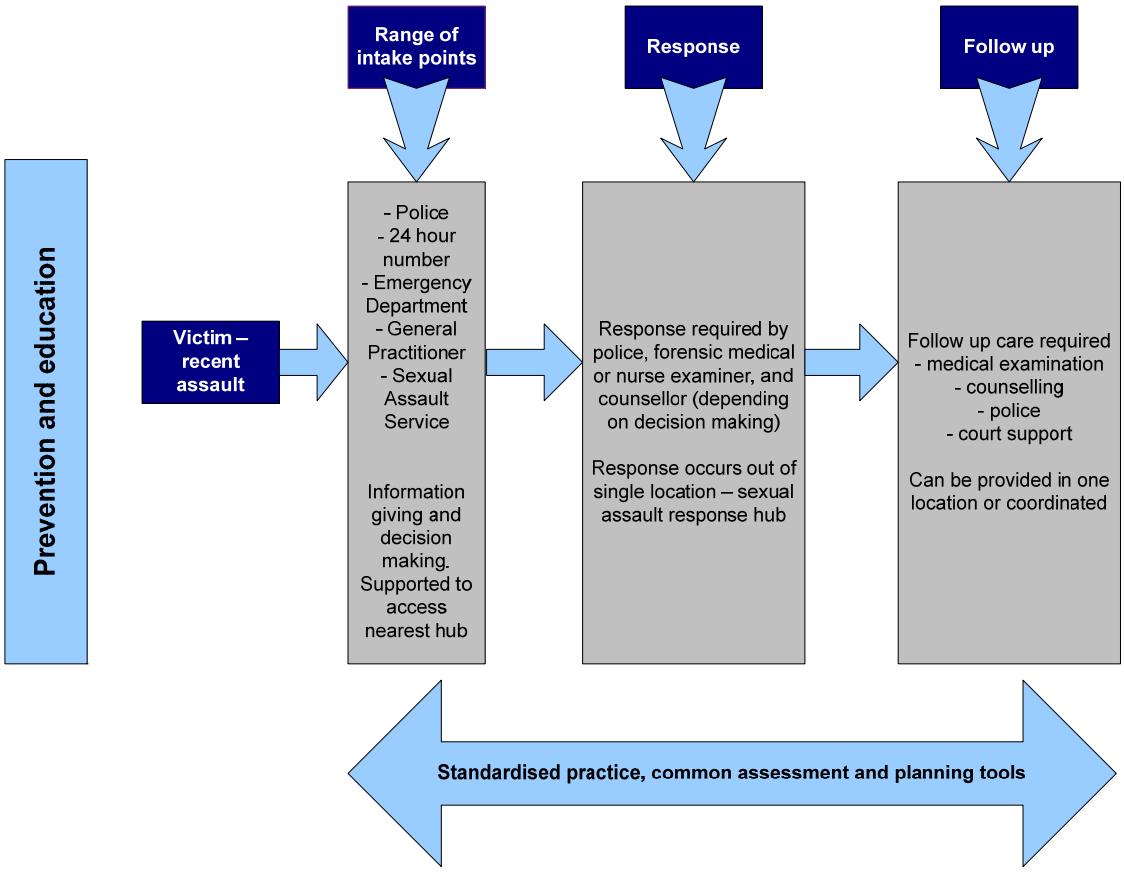
Identification of pathways

Pathways are required for victims of sexual assault to access service provision. Pathways should be identifiable and accessible and lead to an evidence based, best practice response.

Appropriate service access pathways should be developed in conjunction with service system partners in each Health Service District. Communication should then occur to ensure that all stakeholders understand this pathway to service provision, including for victims who have experienced a recent assault or for victims who have experienced sexual assault or abuse in the past. Local protocols would need to be established that support the victim's access to the hub regardless of which entry point they use (for example police or another hospital).

The following diagrams provide an overview of possible pathways for victims of recent assault and survivors of childhood sexual abuse.

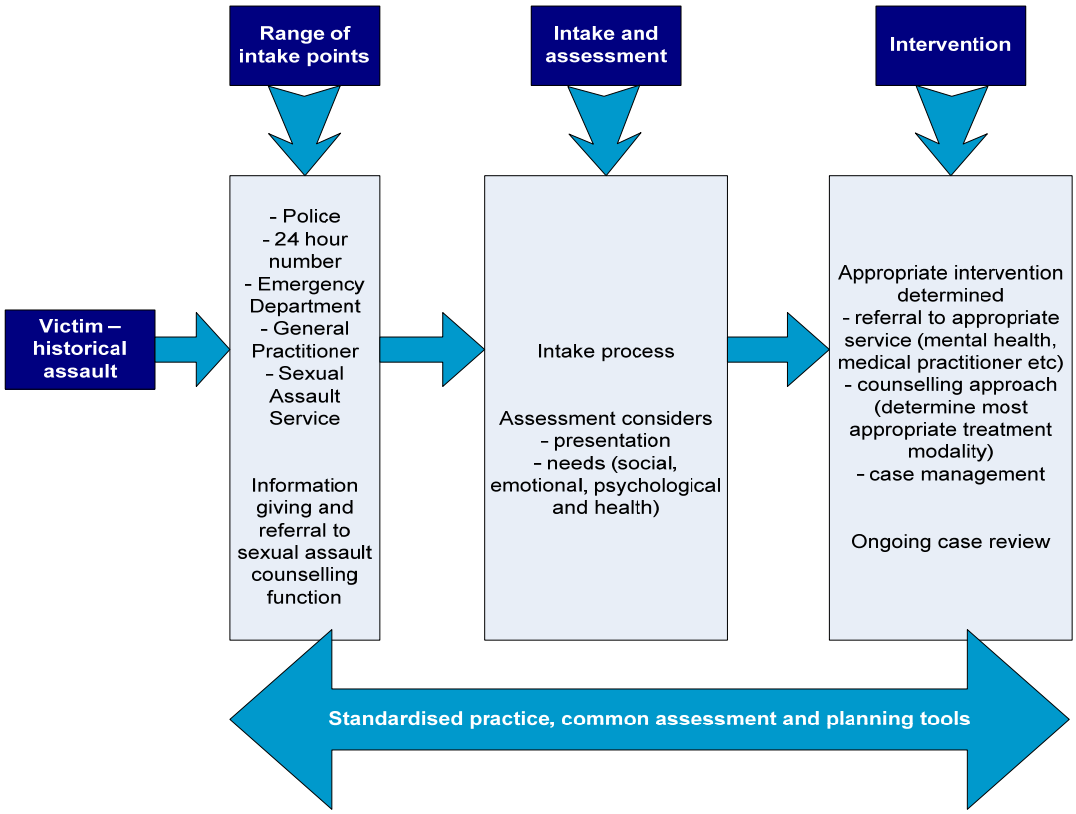
Figure 2: Client pathway after a recent assault



Victims of a recent assault may present to a range of intake points, including police, a 24 hour sexual assault line, a hospital emergency department, general practitioner or a sexual assault service. Regardless of where the presentation occurs, the victim should, at this point, be provided with information in relation to their options for a response. If the victim decides to proceed with a response they should be assisted to attend to the nearest sexual assault response hub.

Victims or survivors of historical abuse could also present at a range of services including their general practitioner, mental health service or sexual assault service. Information should be provided and an assisted referral made to the most appropriate service. This may be the counsellor employed at the sexual assault response hub who would have expertise in sexual assault responses.

Figure 3: Client pathway after historical abuse



Implementation of policy and practice guidance

Health Service Districts would be responsible for implementing policies and procedures developed by Queensland Health at the head office or central level (by the Policy, Planning and Resourcing Division). The leadership function within the Health Service District would be responsible for:

- monitoring service provision at a Health Service District level as per the performance monitoring framework developed by Queensland Health;
- collection of data and reporting on this and any key performance indicators to Queensland Health head office;
- providing support for staff involved in a sexual assault response through hubs;
- coordination and liaison with police and other service providers to monitor quality of service provision at a local level; and
- following up on any complaints or circumstances where service has not been provided in a timely or appropriate manner.

5 Next steps

This review has provided Queensland Health with a starting point to reform the way responses are provided to adult victims of sexual assault. A number of elements for reform have been presented in consideration of the best practice evidence and stakeholder feedback.

This section outlines a series of steps that could be considered by Queensland Health to move ahead with a reform agenda.

5.1 Consultation on the recommendations for reform

In order to facilitate stakeholder 'buy in' for reform, it is important that stakeholders have a reasonable opportunity to comment on the model proposed in this report. Reform of this nature holds implications for multiple government departments, particularly police, and it is appropriate that discussions with these agencies occur.

In the first instance, it may be possible for Queensland Health to convene a senior whole of government taskforce to oversee the reforms.

A series of forums could also be held around Queensland to provide Sexual Assault Services and their service system partners (police, hospitals and the Office of the Director of Public Prosecutions) an opportunity to comment on the proposed model.

Stakeholder consultation at this point would inform the further development of the model and would engender a smoother transition process and provide a foundation for later structural change.

5.2 Queensland Health central office activities

Queensland Health central office could undertake a number of activities in the short term to bring about change, including:

- establishment of a whole of government mechanism for greater collaboration and integration of service systems;
- development of a whole of government policy framework to guide the delivery of sexual assault responses;
- consideration of the costing implications of the proposed model to inform a possible budget submission;
- undertaking an assessment of service needs and gathering evidence to determine the number and type of services required in each Health Service District;
- development of tools to support improved contract management approaches (as per the Queensland Government's *Framework for Investment in Human Services*); and

- consideration of ways to actively engage with funded Sexual Assault Services and promote collaboration and cooperation.

In the medium to longer term, Queensland Health could implement the proposed changes to the service delivery model, including:

- varying funding and contractual arrangements to support the delivery of services through sexual assault service hubs in each of the Health Service Districts;

- funding and contracting with additional sexual assault services outside the hubs as appropriate (eg Indigenous or CALD specific services) on the condition they are integrated with the needs and activities of the service hubs;

- resourcing and overseeing Health Service Districts to implement the sexual assault service hubs;

- developing and implementing service standards and operational protocols;

- increasing its capacity to undertake effective quality management of the service response including establishing performance standards and indicators, monitoring and reporting and providing feedback to promote the continuous improvement of service providers; and

- developing and implementing a professional development framework to build the capacity of the counselling and forensic medical and nursing workforces.

A Project activities and consultation details

A.1 Project activities

A number of activities occurred as a part of this project and these are summarised below:

- detailed examination of contemporary research findings and practice developments in the field of sexual assault, including the identification of relevant evidenced-based best practice principles and models for sexual assault responses (related to the health needs of adult victims);
- identification and analysis of sexual assault service system models in other Australian and relevant overseas jurisdictions incorporating elements of best practice for sexual assault system responses and;
- an analysis of the existing sexual assault system in Queensland.

A.2 Consultation approach

Queensland Health identified agencies and locations to be consulted with as part of this review. Ten Brisbane based services were selected as well as four regional locations (Townsville, Toowoomba, Gold Coast and Sunshine Coast).

The following Brisbane-based consultations occurred:

- Domestic Violence and Sexual Assault Coordinator, Southern Area Health Service;
- Domestic Violence and Sexual Assault Coordinator, Central and Northern Area Health Services;
- Southside Health Service District;
- Zig-Zag Young Women's Resource Centre;
- Immigrant Women's Support Service;
- Murrigunyah;
- DV Connect;
- Clinical Forensic Medicine Unit;
- Spiritus-Kinnections (male sexual assault); and
- Queensland Police (a representative was selected).

Consultations in the four regional areas were arranged with the support of the local Sexual Assault Service. Invitations were extended in each location to Sexual Assault Services in nearby locations, and to local partners in service provision such as police and medical and nursing practitioners. CFMU staff were also met with in Brisbane, Townsville and the Gold Coast.

A major stakeholder forum was held in Brisbane and was open to all Sexual Assault Services and stakeholders including representatives from:

- police;
- prosecutors;
- hospital emergency medicine departments;
- hospital social work departments;
- medical and nursing practitioners and prosecutors;
- medical practitioners;
- sexual assault nurse examiners; and
- sexual assault counsellors.

This forum was designed to hear feedback from stakeholders on gaps in the current service system and to seek input into components of a new service system model.

Written submissions were also invited and were received from eight service providers.

A full list of stakeholders consulted with as part of this review is provided at Appendix A.

A.3 Project governance

Queensland Health established a steering committee to oversee the review. This group consisted of:[139]

- Sandra Eyre, Acting Senior Director Policy Branch (chair);
- Dr Bob Hoskins, Director, Clinical Forensic Medicine Unit;
- Corelle Davies, Senior Director, Maternity Child Health and Safety Branch;

[139] Queensland Health invited other stakeholders to attend some meetings of the steering committee at key milestones of the project.

- Kim Woolgar, Director, Community Services Unit-Health Purchasing and Logistics; and
- Janet Martin, Acting Manager, Strategic Policy Unit, Mental Health Branch.

The Project Manager for Queensland Health was Rachel Vowles, Acting Principal Policy Officer, Policy Branch.

A.4 Stakeholders consulted

The following stakeholders were consulted through either:

- face-to-face consultation;
- telephone consultation; or
- participation at a statewide forum.

Karen	(surname)	BRISCC
Anna	(surname)	BRISCC
Annabelle	Allimant	Immigrant Women's Support Service
Karren	Aspinall	Sunshine Coast Service Against Sexual Violence
Rachel	Bale	Centre Against Sexual Violence
Marlene	Berry	CSU, Queensland Health
Barbara	Blair	Phoenix House, Bundaberg
Heidi	Bone	BRISSC
Glenn	Bradley	Executive Director, Southside Health Service District
Adela	Brent	Zig Zag Young Women's Resource Centre
Peter	Brewer	Queensland Police
Helen	Bruder	Nambour General Hospital
Karen	Buggs	Rockhampton Rape, Incest and SV
Julie	Campbell	Sexual Assault Service
Rowena	Chapman	Tablelands Sexual Assault Service
Mitchell	Clark	Gold Coast Centre Against Sexual Violence
Cathy	Crawford	North Queensland Combined Women's Service
Amanda	Deardon	BRISCC

Amanda	Dederer	Clinical Forensic Medical Unit
Karen	Fearnie	Sexual Assault Service
Erica	Fernandez	Zig Zag Young Women's Resource Centre
Dr Geoff	Fisher	Clinical Forensic Medical Unit
Dr Gary	Foster	Spiritus – Kinnections
Kedell	Fotinos	Clinical Forensic Medical Unit, Townsville Hospital
Glenys	Gibson	Sexual Assault Coordinator, Bayside Sexual Assault
Rose	Gordon	Queensland Health, Sexual Health Service
Jillian	Grant	Whitsunday Sexual Assault Service
Kate	Gimson	Sexual Assault and Domestic Violence Coordinator, Southern Area Health Service
Lee	Hammond	South West HSD Health Promotion
John	Hooper	Sexual Assault Service
Dr Bob	Hoskins	Clinical Forensic Medical Unit
Gina	Jacobsen-Hubbs	Southside Health Service District
Mahala	Jagoe	Redcliffe Community Health, Caboolture
Lisa	James	Queensland Health
Judy	Kelly	Sexual Assault Services Roma
Penny	Kenchington	Queensland Health Sexual Health Service
Greg	King	Relationships Australia
Hilary	Knack	Qld Assoc for Healthy Communities
Steve	Koesra	Redcliffe Hospital
Sheena	Liley	Relationships Australia
Dr Cathy	Lincoln	Clinical Forensic Medical Unit
Hannah	Lupo	Hackay Sexual Health and Sexual Assault
Di	Macleod	Gold Coast Centre Against Sexual Violence
Dr Ian	Mahoney	Clinical Forensic Medical Unit
Di	Mangan	DV Connect
Mark	Matiussi	District Manager, Southside Health Service District
Christy	McGuire	Zig Zag Young Women's Resource Centre

Kelly	McKenna	CHSAS Emerald
Sheri	Merenda	Murrigunyah
Lydia	Mirabito	Clinical Forensic Medical Unit
Denise	Morgan	Queensland Health
Deb	Neucom	Clinical Forensic Medical Unit
Andrew	Nicholson	Relationships Australia
Leonie	Nord	Widebay Sexual Assault Service
Cathy	North	West Moreton Women's Health
Anne	O'Donoghue	Nambour General Hospital
Carol	Olsen-Bull	CASV
Beata	Ostapiej-Piatkowski	Immigrant Women's Support Service
John	Patten	North Brisbane
Peter	Pendlebury	Relationships Australia
Sonja	Pichler	Queensland Health, Sexual Health Service, Clinical Nursing Team
Narelle	Poole	Gold Coast Centre Against Sexual Violence
Kathy	Prentice	Phoenix House, Bundaberg
Di	Proctor	Sunshine Coast Service Against Sexual Violence
John	Rallings	Queensland Health , Sexual Health Service
Fiona	Richardson-Clarke	West Moreton Women's Health
Wendell	Rosevear	Stonewall Medical Centre / MARS
Kim	Scott	Sunshine Coast Service Against Sexual Violence
Jan	Seeton	Laurel House S.C.S.A.S.V.
Darrin	Shadlow	Qld Police
Jessica	Siles	Nambour General Hospital
Bernice	Smith	Sexual Assault and Domestic Violence Coordinator, Central and Northern Area Health Service
Kerry	Smith	Family Planning Queensland
Lou	Strodfelt	Queensland Police
Jan	Sweeton	Sunshine Coast Service Against Sexual Violence
T.J.	Tan	Stonewall Medical Centre / MARS

Rachel	Thiele	Domestic and Family Violence Prevention Service (Relationships Australia)
Kirsten	Thompson	Queensland Health, Sexual Health Service
Belinda	Vincent	North Queensland Combined Women's Service
Warren	Webber	Queensland Police
Helen	Weismann	Queensland Healt,h Sexual Health Service
Anthony	West	Queensland Health
Kellie	Wilk	Gold Coast Centre Against Sexual Violence
Steve	Windsor	Queensland Police

A.5 Written submissions

The following organisations or individuals provided a written submission to the review:

- Zig Zag Young Women's Resource Centre;
- Dr Wendell Rosevear;
- Centre Against Sexual Violence;
- Rockhampton Women's Health Centre;
- Gold Coast Centre Against Sexual Violence;
- Mackay Sexual Health and Sexual Assault Unit;
- Phoenix House; and
- Queensland Association for Healthy Communities.

A.6 Other jurisdictions

Victoria - Tania Farha, Project Manager, Multi-Disciplinary Centre Pilot, Victoria Police

Western Australia – Denise Nicholls, Manager, King Edward Memorial Hospital for Women Sexual Assault Referral Centre

Northern Territory – Barbara Kelly, Manager for Sexual Assault Referral Centres

B Jurisdictional overview

An overview of responses provided in some international jurisdictions where service delivery is co-located or well integrated is presented below.

B.1 United Kingdom

Sexual Assault Referral Centres (SARCs) have been established in the UK for adult victims of recent sexual assault, and provide both a crisis response and follow-up services. Since the first centre began operating in the late 1980s (St Mary's), 19 SARCs have been established, and it is expected that this number would grow as funding continues to increase.[140] Two models of SARCs have been implemented:

- a fully integrated co-located model; and
- an integrated but outsourced or networked model

Co-located model – St Marys

St Marys in Manchester is an example of the co-located model. It is hospital-based and provides a 24 hour coordinated response to male and female sexual assault victims, including forensic and medical examinations, counselling, screening for STIs and HIV counselling, pregnancy testing and 24 hour telephone support.[141] Access to services does not depend on reporting the assault to the police, however most clients are police-referred.[142]

When a client arrives at St Marys, they are met by a crisis worker who provides support and information until the conclusion of the medical examination. Forensic doctors and part-time forensic nurses are available to undertake forensic and medical examinations with client consent. Medical examinations are undertaken in a room close to the hospital reception area. Forensic samples may be stored until the client decides whether to proceed with a criminal justice response or to have the samples destroyed. Police are present to brief medical personnel and provide law enforcement support.[143]

Following the crisis response, additional services are outlined to the victim, and follow-up contact is made by a support worker who can assist the client to make a statement (if applicable) and facilitate their access to additional services, including unlimited counselling services at St Marys.

[140] Home Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.
[141] Ibid.
[142] Lovett, J, Regan, L & Kelly, L 2004, *Sexual Assault Referral Centres: developing good practice and maximising potentials*, Home Office, London.
[143] Home Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.

Co-located model - REACH

REACH (Rape, Examination, Advice, Counselling and Help) is another example of co-located service provision and provides services to both men and women aged 16 years and over. REACH consists of two centres, one based in a hospital and one in a residential location. Both of these facilities have examination rooms, an interview room (for use by police) and counselling rooms. Services provided at REACH include forensic examinations, medical follow-up and individual counselling and group counselling. Victims of assault can be referred via a number of pathways including self referral and through the police.

Outsourced model - STAR

The Surviving Trauma After Rape (STAR) service in West Yorkshire is an example of the outsourced model. Services are provided on a sessional basis using services located close to the client's home, rather than centrally from one location. STAR provides counselling, support and advocacy services through coordinating Initial Support Workers that visit the victim at home or in a place convenient to them, and referrals to local accredited counselling services. STAR does not provide medical or forensic services but it assigns a "case tracker" to clients whose matters proceed through the criminal justice system. The case tracker keeps in contact with police, courts and the Crown Prosecution Service and keeps the client informed of progress. [144]

Effectiveness of SARCs

One evaluation of these three approaches has compared responses in areas with a SARC (SARC and REACH) with those provided in areas without co-located service delivery (STAR). The evaluation findings concluded that service delivery through SARCs was preferable, and that:

- clients were more likely to have a forensic medical examination in areas where there are SARCs;
- victims using the co-located services (St Marys and REACH) rated the environment and conduct of the forensic examination more highly; and
- the co-located services provided a quicker and more consistent service.[145]

The evaluation also found that:

- the crisis workers at one of the co-located services (St Marys) were rated the highest in terms of support services (this was attributed to the higher number of forensic examinations conducted at St Marys);

[144] Surviving Trauma After Rape n.d., *Description of Service*, STAR, West Yorkshire, viewed 2 September 2008, http://www.starproject.co.uk/services.htm.
[145] Lovett, J, Regan, L & Kelly, L 2004, *Sexual Assault Referral Centres: developing good practice and maximising potentials*, Home Office, London.

- St Marys were able to proactively able to engage victims in follow up counselling. This approach was strongly endorsed in the evaluation and revealed unmet needs in victims attending other services (such as ongoing support and liaison with police and courts); and

- the 'opt-in' approach to counselling used at STAR resulted in reduced update.

Further evaluation has been undertaken by a team from the UK Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Unit. This evaluation assessed three different SARCs in terms of their development, impact, overall costings and cost effectiveness and concluded that:

- SARCs are a concept to enhance care of victims of sexual assault (more than just a building);

- SARC users are more likely to consent to forensic examination;

- the majority of women attending SARCs are examined by female medical examiners;

- there is no evidence that SARC users are more likely to report the assault to the police; and

- one third of victims using SARCs access counselling services. [146]

From this study it can be concluded that SARCS continue to provide a responsive service to victims of sexual assault where victims can have access to female medical practitioners and counselling and support. This study has found that more victims accessing a forensic medical service however, does not necessarily equate to more reports to police.

The UK Home Office now promotes SARCs as the best practice model for responding to sexual assault victims. The British Government has outlined an intention to provide a network of SARCs to enable access for victims nationwide.[147]

B.2 United States

In the United States, Sexual Assault Response Teams (SART) are coordinated, multidisciplinary teams of primary and secondary responders for victims of sexual assault. Primary responders include law enforcement officers, advocates or counsellors, forensic medical examiners and medical practitioners. Secondary responders include social workers, counsellors, victim advocates and healthcare providers of follow up treatment.

A SART conducts an initial team interview with the victim, requiring the victim to tell the story of the assault only once. Each SART also meets regularly to review individual cases to ensure coordination and an optimal response, review team performance and consider systemic issues.

[146] Royal College of Obstetricians and Gynaecologists – Clinical Effectiveness Unit 2006, *Is there any available evidence on the evaluation of Sexual Assault Referral Centres?* RCOG, London.
[147] Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.

The SART can also identify and facilitate solutions to other issues, such as housing and mental health.[148]

As of 2005 there were approximately 800 SARTs in operation throughout the US and Canada.[149]

Effectiveness of SARTs

Reviews of the effectiveness of SARTs have identified:

- an increased number of charges filed for sexual assault offences, a lower likelihood of dismissal in court and greater chance of a charge in a Superior Court;
- a clear appreciation of the service by sexual assault victims;[150]
- reduced waiting time for service responses;
- improved quality of documentation;
- improved maintenance of the chain of evidence;
- better interagency service coordination; and
- improved victim satisfaction. [151] [152]

Positive service practices arising from interagency collaboration through the SARTS include:[153]

- victim centred, agency-specific guidelines and protocols;
- recommendations for meeting the needs of victim subgroups;
- cross-training across disciplines;
- case management;

[148] National Sexual Violence Resource Center 2006, *Report on the National Needs Assessment of Sexual Assault Response Teams*, NSVRC, Pennsylvania.
[149] Girardin, B 2005, 'The Sexual Assault Nurse Examiner: A win-win solution', *Topics in Emergency Medicine*, vol. 27, no. 3, pp.124-31.
[150] Wilson, D & Klein, A 2005, *An evaluation of the Rhode Island Sexual Assault Response Team (SART)*, Botec Analysis Corporation, Massachusetts.
[151] Smith, K et al 1998, 'Sexual Assault Response Team: overcoming obstacles to program development', *Journal of Emergency Nursing*, vol. 24, no. 4, pp.365-7.
[152] Dandino-Abbott, D 1999, 'Birth of a sexual assault response team: the first year of the Lucas County/Toledo, Ohio SART program', *Journal of Emergency Nursing*, vol. 25, no. 4, pp.333-6.
[153] National Sexual Violence Resource Center 2006, *Report on the National Needs Assessment of Sexual Assault Response Teams*, NSVRC, Pennsylvania.

- data collection and tracking of criminal justice outcomes; and
- community education.

B.3 South Africa

The Sexual Offences and Community Affairs (SOCA) Unit was established in the National Prosecuting Authority of South Africa in 1999.[154] The objectives of SOCA are to:

- improve the conviction rate in gender-based crimes and crimes against children;
- actively protect vulnerable groups from abuse and violence;
- ensure access to maintenance support; and
- systematically reduce secondary victimisation.

A series of rape care centres – Thuthuzela Care Centres (TCCs) – have been established in South Africa by SOCA and are recognised by the United Nations General Assembly as a "world best practice model" for multidisciplinary response to gender based violence. These centres provide a co-located integrated response from public hospitals in communities where the incidence of rape is particularly high. The model streamlines service delivery and allows investigative, prosecutorial, medical and psychological services to be provided in one location. A range of multidisciplinary personnel including health care professionals, counsellors, police and prosecutors work as a team at the centres. The TCCs are in close proximity to the specialist sexual offence courts.

Referral to TCCs typically occurs through the ambulance service, with each member of the multidisciplinary team performing defined roles as follows:

- a medical practitioner performs a forensic and medical examination;
- an investigation officer interviews the victim following the medical examination and takes a statement;
- a social worker or nurse provides support and arranges follow-up counselling, medical visits and treatment; and
- the victim is able to consult with a specialist prosecutor and is provided with information about the legal process.

Following the crisis response the victim is provided with transportation home or to a place of safety.

[154] Sexual Offences and Community Affairs Unit 2008, 'Annual report 2006/2007 & additional information on 2007/2008', National Prosecuting Authority, Pretoria, viewed 3 September 2008, www.pmg.org.za/files/docs/080521soca.ppt.

An interdepartmental team involving Justice, Health, Education, Treasury, Correctional Services, Safety and Security, Local Government and Home Affairs manages the centres with funding and technical assistance from UNICEF and the Danish Government.

As of 2007, 10 TCCs had been established, with a goal of 42 by the end of 2009.

Although this South African approach has not been formally evaluated, anecdotal outcomes include better support for victims and reduced time from investigation to prosecution and conviction (from up to five years to less than six months). Rates of conviction have also increased by nine per cent over a five-year period to 2006/2007. Performance assessment should be enhanced in future years by the recent implementation of quality assurance mechanisms including an audit tool.

B.4 Malaysia

The accident and emergency department of the Kuala Lumpur Hospital in Malaysia was the first in the country to offer a coordinated inter-agency response to sexual assault victims.[155] Established in 1993, the service provided an example of a service capable of enabling victims to access medical, legal, psychological social services in a single location. Its success led to the Malaysian Ministry for Health establishing 34 similar centres throughout the country. Challenges over the years have been overcome by the following improvements:

- better attitudes of hospital staff;
- more forensic medical officers; and
- more adequate accommodation for victims.

Although there has been no formal evaluation of the Malaysian approach, evidence shows that significant innovation has been possible in a resource-limited environment, speculating that countries with shorter histories of responding to sexual assault have had 'less time and opportunity for [destructive] *turf* issues to develop.'[156]

B.5 Scandinavia

Centres of Excellence, developed in Scandinavia, are hospital-based and specialise in crisis responses to sexual assault.[157] They provide a range of services including forensic and medical examinations, emergency treatment and crisis counselling. Some centres also provide longer term counselling support and advocacy. These centres often undertake and publish research about best practice treatment approaches for sexual assault and implement practices grounded in a strong evidence base.

[155] World health Organisation (2002), *World report on violence and health*, World Health Organisation, Geneva.
[156] Kelly L, Regan L (2003), *Good practice in medical responses to recently reported rape, especially forensic examinations*, Child and Woman Abuse Studies Unit, London Metropolitan University, London.
[157] Ibid.

B.6 Australian jurisdictions

The table below provides a summary of elements of service delivery across Australia where the information has been publicly available. The specific elements detailed include:

- funding allocation and governance;
- lead agency;
- counselling and Support Response;
- forensic and medical response;
- response protocols;
- response partners;
- service delivery in rural and remote areas;
- specialist responses; and
- remote service delivery.

Table 4: Overview of service delivery in jurisdictions throughout Australia

New South Wales	
Funding allocation and governance	New South Wales (NSW) Department of Health allocates funding to Area Health Services which in turn fund and manage Sexual Assault Services. NSW Health monitors performance of all Sexual Assault Services through data collection mechanisms. Governance is provided by Local Coordination Committee Meetings, Sexual Assault Review Committee, and the NSW Adult Sexual Assault Interagency Committee.
Lead agency	New South Wales (NSW) Department of Health.
Counselling and Support Response	Services to men, women and children, including crisis support, counselling, court advocacy, criminal justice support and information for victims of sexual assault are provided through a network of 55 specialist Sexual Assault Services. A 24-hour counselling and referral service is operated by the NSW Rape Crisis Centre (also funded by NSW Department of Health). The NSW Rape Crisis Centre is operates under a feminist framework and is aimed at adult women.
Forensic and medical response[158]	• Forensic Examiner: NSW Health employees (emergency departments), General Practitioners or Sexual Assault Service doctors (limited). • Evidence is stored for three months. Permission must be sought to destroy evidence. • Each Area Health Service is responsible for providing forensic and medical services as best suited to the region. The Sexual Assault Services are usually located near to a hospital, however strategies including employment or contracting of a medical officer, voluntary on-call rosters, or transferring victims to alternate locations are all used.

[158] These services were reviewed by KPMG in 2007

New South Wales	
Response protocols	The *NSW Interagency Guidelines for Responding to Adult Victims of Sexual Assault* is the primary document and it references the New South Wales Police *Investigation and Management of Adult Sexual Assault and standard Operating Procedures* and the *Office of the Director of Public Prosecutions Policy and Guidelines.*
Response partners	NSW Department of Health, NSW Police, NSW Office of the Director of Public Prosecutions are parties to the *NSW Interagency Guidelines for Responding to Adult Victims of Sexual Assault.*
Service delivery in rural and remote areas	Coordinated by each Area Health Service as appropriate although there are considerable challenges in locating doctors to undertake medical and forensic examinations
Specialist services	No specialist services, however Sexual Assault Services respond to all victims
Training provided	Education Centre Against Violence is funded through contract with NSW Health to provide training in sexual assault to medical and counselling staff

South Australia	
Funding allocation and governance	The Department of Health funds Yarrow Place Rape and Sexual Assault Service which is located in Adelaide
Lead agency	Yarrow Place provides services for men and women over 16 and works with hospital Emergency Departments to coordinate a statewide response The Child Protection Unit at the Women's and Children's Hospital in Adelaide provides medical, forensic, counselling and support services to children who have been victims of sexual assault.
Counselling and support response	Yarrow Place provides services including crisis response service (include medical, counselling, advocacy), forensic medical examinations, court preparation and support
Forensic and medical response	• Forensic Examiner: Yarrow Place doctor. • Provides support and training to doctors in Emergency Departments in other hospital settings undertaking forensic examinations • Evidence can be stored for three months at Yarrow Place, and then a further three months at the Forensic Science Centre. • Paediatricians at the Child Protection Unit at the Women's and Children's Hospital provide acute medical and forensic services to children.
Response protocols	*Medical Care for Sexual Assault Victims*.
Response partners	Yarrow Place specifically aims to provide support and information to individual doctors responding to sexual assault. There are no formalised partnerships with other agencies. A Memorandum of Understanding also exists with the South Australia Police to facilitate coordination

South Australia	
Service delivery in rural and remote areas	Yarrow Place provides training for police, social workers and health workers outside of Adelaide, in addition to 24 hour telephone advice and support to workers in rural and regional areas who respond to sexual assault.
Specialist services	Yarrow Place has 2 Aboriginal Sexual Assault workers who provide counselling and training and community education. Yarrow Place has also developed guidelines for referrals from correctional services.
Training provided	Yarrow Place provides a range of accredited education, documentation and support kits to doctors and other relevant processionals.

.

Western Australia	
Funding sources and allocation	The Department for Communities funds the Sexual Assault Resource Centre (SARC) at King Edward Hospital Perth.
Lead agency	The SARC provides services for men and women over 13. The Child Protection Unit at the Princess Margaret Hospital provides forensic and medical services for children and employs a social worker for follow up.
Counselling and support response	The SARC provides a 24 hour crisis line staffed by nurses, and a counselling line. Individual and group counselling is also available.
Forensic and medical response	• Forensic Examiner: SARC doctor. • Evidence is held for three months. • SARC doctors also provide medical treatment for recent (within 2 weeks) assaults.
Response protocols	*Management of Alleged Recent Sexual Assault: Information for Metropolitan Emergency Departments.*
Response partners	SARC, Western Australian Police and hospital (EDs).
Service delivery in rural and remote areas	Where there is no sexual assault service callers will be directed to an Emergency Department and then to a social worker or equivalent for follow-up. The Eastern Goldfields Sexual Assault Resource Centre provides 24 hour crisis counselling and support response for people aged 13 years and over. Kits are generally kept on hand at regional and remote hospitals throughout Western Australia, and if necessary a Perth SARC doctor can provide advice to regional doctors to undertake a forensic exam.
Specialist services	The Perth SARC has an Aboriginal Liaison Officer.

Western Australia	
Training provided	The Perth SARC provides training to workers including health and welfare professionals, police, medical staff, Aboriginal workers and the legal system. Also provides education to secondary school students. Training is also provided by SARC doctors to remote area community workers.

Tasmania	
Funding sources and allocation	The Department of Health and Human Services funds the following non-government organisations to respond to victims of sexual assault: • Sexual Assault Support Service in Hobart; • Laurel House - Northern Sexual Assault Group in Launceston; and • North West Centre Against Sexual Abuse in Burnie.
Lead agency	There is no lead agency
Counselling and support response	SASS, Laurel House - Northern Sexual Assault Group in Launceston and North West Centre Against Sexual Abuse in Burnie all provide counselling, support and information for male and female victims of all ages and careers of children who have been victims of sexual assault. Services for children are generally provided through emergency department, private paediatric or general practice settings, services are ad hoc with no clear pathways into the health care system. SASS provides a 24 hour crisis line, counselling, support and information for male and female victims of all ages and carers of children who have been victims of sexual assault.
Forensic and medical response	• Forensic Examiner: Sexual Assault Medical Service (SAMS) doctor. SAMS is located at the Royal Hobart Hospital. • Evidence is held for six weeks. • Access to forensic examination in North West and Northern areas occurs through local hospitals
Response protocols	*Policies and procedures for after hours and on call.*

Tasmania	
Response partners	SASS and SAMS, Tasmania Police Hobart.
Service delivery in rural and remote areas	Laurel House – Northern Sexual Assault Group, Launceston. North West Centre Against Sexual Abuse, Burnie.
Specialist services	Male victims have their medical and forensic needs met through emergency departments rather than through SAMS.
Training provided	SASS provides education to Tasmanian police recruits, healthcare workers and relevant community agencies.

Victoria	
Funding sources and allocation	Funding is allocated through the Department of Human Services to the Centres Against Sexual Assault.
Lead agency	Centres Against Sexual Assault (CASAs), of which there are 15.
Counselling and support response	CASAs provide a 24 hour crisis line which can includes access to medical and legal advice where necessary. CASAs all provide information, support and advocacy, counselling, referral to victims of all ages. CASAs also undertake research and resource development. The Gatehouse Centre at the Royal Children's Hospital and the Child Protection Unit at the South Eastern CASA provide specialist services to children.
Forensic and medical response	• Examiner: Victorian Institute of Forensic Medicine Forensic Physician. Forensic examinations are only undertaken on victims who have reported to police and are not collected and stored otherwise (this policy is currently under review).
Response protocols	*Services to Adult and Child Victims of Sexual Assault: Guidelines for Providers.*
Response partners	Responses to victims are coordinated through CASAs and include: • CASAs • Victorian Institute of Forensic Medicine (VIFM) • The Gatehouse Centre at the Royal Children's Hospital • The Child Protection Unit at the South Eastern CASA • Victorian Sexual Assault Crisis Line (after hours)

Victoria	
	• Victoria Police and Courts
Service delivery in rural and remote areas	CASAs provide services all over Victoria. Where necessary CASAs have established panels of doctors who function as part-time forensic medical officers (overseen by VIFM).
Specialist services	
Training provided	Training in responding to sexual assault is delivered by most Victorian CASAs by arrangement with local agencies and police in their regions. Forensic training is provided by VIFM and includes an academic program delivered through Monash University.

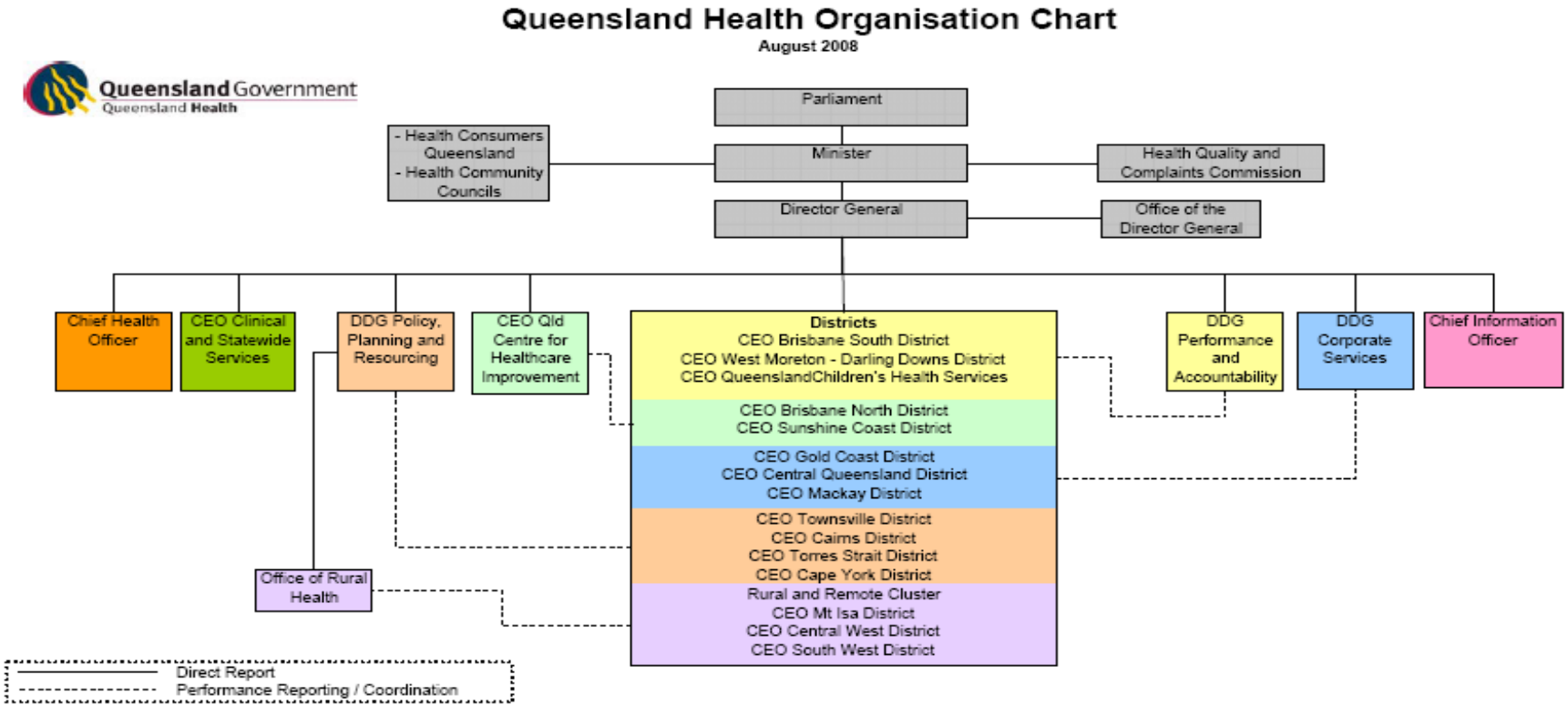
Northern Territory	
Funding sources and allocation	The Department of Health and Families funds the Darwin and Katherine Sexual Assault Referral Centres, the Katherine Family Link Service, and the Tennant Creek Sexual Assault Counsellor.
Lead agency	Darwin Sexual Assault Referral Centre (SARC).
Counselling and support response	Darwin SARC provides counselling for male and female adults and children, information, support through the legal process and counselling for victims, partners, family members and significant others.
Forensic and initial response	• Forensic examinations conducted at Darwin SARC by rostered SARC doctors drawn from a pool of GPs, Paediatricians and Sexual Health Practitioners all of whom are women. • Evidence is held for three months (there is some flexibility).
Response protocols	*A Coordinated Response to Childhood Sexual Assault in the Top End*. No formal Territory-wide protocol applicable to responding to adult victim/survivors of sexual assault.
Response partners	• The Department of Health and Communities • Sexual Assault Referral Centre (SARC) • Ruby Gaea Centre Against Rape • Northern Territory Police • General Practitioners • Emergency Department of the Royal Darwin Hospital • Australian Hotels Association Northern Territory

Northern Territory	
Service delivery in rural and remote areas	• Alice Springs SARC • Katherine - Family Link • Tennant Creek - Sexual Assault Counsellor
Specialist services	There is an Aboriginal Sexual Assault Counsellor available at Darwin SARC. In Darwin the Ruby Gaea organisation offers services to women and children from a feminist perspective, Ruby Gaea is also funded by the Department of Health and Families.
Training provided	Darwin SARC provides some community education.

Australian Capital Territory	
Funding sources and allocation	The Department of Disability, Housing and Community Services funds the Canberra Rape Crisis Centre.
Lead agency	Canberra Rape Crisis Centre (CRCC).
Counselling and support response	CRCC provides a 24 hour crisis and counselling line, counselling for women and children, advocacy for women and children, support though legal and medical procedures, referral, support groups and a free information library and education workshops for schools.
Forensic and initial response	• Forensic Examiner: Commonwealth Medical Officers, and a roster of trained female doctors. • Evidence is held for two weeks and an extension can be negotiated.
Response protocols	
Response partners	• Australian Federal Police • Canberra Rape Crisis Centre • Service Assisting Male Survivors of Sexual Assault • Forensic and Medical Sexual Assault Centre (the Canberra Hospital) • Sexual Assault and Child Abuse Team
Service delivery in rural and remote areas	N/A
Specialist services	The Service Assisting Male Survivors of Sexual Assault (SAMSSA) provides service to men (auspice through CRCC)

Australian Capital Territory	
Training provided	Training is provided to Australian Federal Police recruits and detectives within SACAT Tailored training is available on request to various government and community organisations including schools.

C Revised Queensland Health structure



D Bibliography

Astbury, J 2006, 'Services for victim/survivors of sexual assault: Identifying needs, interventions and provision of services in Australia', Australian Centre for the Study of Sexual Assault, Melbourne.

Attorney General's Department of NSW 2005, *Responding to sexual assault: the way forward*, Attorney General's Department NSW, Sydney.

Australian Bureau of Statistics 2003, *Sexual assault information development framework*, ABS, cat. no. 4518.0, Canberra.

Australian Bureau of Statistics 2004, *Sexual assault in Australia: a statistical overview*, ABS, cat. no. 4523.0, Canberra.

Australian Bureau of Statistics 2004, *Sexual assault in Australia: a statistical overview*, ABS, cat. no. 4523.0, Canberra.

Australian Bureau of Statistics 2005, *Crime and Safety*, Australia, ABS Cat 4509.0, Canberra.

Australian Bureau of Statistics 2005, *Personal Safety Survey*, ABS, Canberra.

Australian Bureau of Statistics 2006, *Recorded Crime – Victims*, ABS Cat 4150.0, Canberra.

Australian Centre for the Study of Sexual Assault 2003, 'Male survivors of sexual assault', *Aware: newsletter of the Australian Centre for the Study of Sexual Assault*, Issue 2, Australian Institute of Family Studies.

Australian Centre for the Study of Sexual Assault 2005, 'Good practice around Australia', *Aware: newsletter of the Australian Centre for the Study of Sexual Assault*, Issue 7, Australian Institute of Family Studies.

Australian Family and Domestic Violence Clearinghouse 2007, University NSW, viewed August 2008, http://www.austdvclearinghouse.unsw.edu.au/au_resources.html

Australian Institute of Criminology 2007, *Australian crime: facts and figures 2006*, Australian Bureau of Statistics, Canberra.

Australian Institute of Criminology 2008, *Sexual Assault Statistics*, accessed 4 June 2008, http://www.aic.gov.au/topics/violence/sexual_assault/stats/

Beaglehole, R, Bonita, R & Kjellstrom 1993, *Basic epidemiology*, World Health Organisation, Geneva.

Better Health Channel, 2007, viewed December 2008, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Sexual_assault?OpenDocument.

Campbell, R, Patterson, D & Lichty, L 2005, 'The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes', *Trauma, Violence & Abuse*, vol. 6, no. 4, pp.313-29.

Casteel, C et al 2008, 'National study of physical and sexual assault among women with disabilities', *Injury Prevention*, vol. 14, pp.87-90.

Casteel, C et al 2008, 'National study of physical and sexual assault among women with disabilities', *Injury Prevention*, vol. 14, pp.87-90.

Chowdhury-Hawkins, R et al 2008, '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, pp.363-7.

Chowdhury-Hawkins, R et al 2008, '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, pp.363-7.

Christina Gleeson 2008, *Basic concepts in crisis theory*, Suite101.com, viewed February 2009, http://psychology.suite101.com/article.cfm/basic_concepts_in_crisis_theory.

Criminal Code Act (Queensland), 1899.

Crome, S 2006, *Male survivors of sexual assault and rape*, Australian Centre for the Study of Sexual Assault, Melbourne.

Cybulska, B 2007, 'Sexual assault: key issues', *Journal of the Royal Society of Medicine*, vol. 100, pp.321-4.

Dandino-Abbott, D 1999, 'Birth of a sexual assault response team: the first year of the Lucas County/Toledo, Ohio SART program', *Journal of Emergency Nursing*, vol. 25, no. 4, pp.333-6.

Davies, M & Rogers, P 2006, Perceptions of male victims in depicted sexual assaults: A review the literature. *Aggression and Violence Behaviour, 11*, 367-377.

Denborough, D 2005, 'Prisoner rape support package', *The International Journal of Narrative Therapy and Community Work*, vol. 2, pp. 29-37.

Education Centre Against Violence 2009, NSW Health, viewed November 2008, http://www.ecav.health.nsw.gov.au/.

Ellis, CD 2002, 'Male rape – the silent victims', *Collegian*, vol. 9, no. 4, pp.34-9.

Ermacora, J 1998, 'It's different in the country…', *Women Against Violence: An Australian Feminist Journal*, vol. 4, pp.36-44.

Fleming, J, Mullen, P, Sibthorpe, B, and Bammer, G, 1999, The long term impact of childhood sexual abuse in Australian women, *Child Abuse and Neglect*, Vol. 23, Issue 2, pp 145-159.

Girardin, B 2005, 'The Sexual Assault Nurse Examiner: A win-win solution', *Topics in Emergency Medicine*, vol. 27, no. 3, pp.124-31.

Goodfellow, J & Camilleri, M 2003, 'Beyond Belief, Beyond Justice: the difficulties for victim/survivors with disabilities when reporting sexual assault and seeking justice', *Final Report – stage one of the Sexual Offences project*, Disability Discrimination Legal Service, Melbourne.

Graycar, AD 2000, *New research on victims of crime in Australia: Victims' needs, victims' rights, an Australian Institute of Criminology report*, Australian Institute of Criminology, Canberra.

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

Home Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.

Home Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.

Hopper, J 2008, *Sexual abuse of males: Prevalence, possible lasting effects and resources*, viewed February 2009, http://www.jimhopper.com/male-ab

Jaycox, LH, Zoellner, L & Foa, EB 2002, 'Cognitive-behavior therapy for PTSD in rape survivors', *Journal of Clinical Psychology*, vol. 58, no. 8, pp.891-906.

Johnson, B, 2005, John Curtin Institute of Public Policy, Institute of Public Administration of Australia, Department of Premier and Cabinet, veiwed December 2008, http://www.jcipp.curtin.edu.au/local/docs/discussion/2005/1.05_%20Bev%20Johnson_Strategies%20for%20Joined%20Up%20Government%20Initiatives%20-%20Final.pdf.

Keel, M 2004, 'Family violence and sexual assault in Indigenous communities: walking the talk', *Briefing, no. 4* Australian Institute of Family Studies.

Kelly K, Moon G, Bradshaw Y, Savage S. *Insult to injury? The medical investigation of rape in England and Wales.* J Soc Wel Fam L. 1998;20(4):409–20. Cited in Chowdhury-Hawkins, R et al 2008

Kelly L, Regan L (2003), *Good practice in medical responses to recently reported rape, especially forensic examinations*, Child and Woman Abuse Studies Unit, London Metropolitan University, London.

Lay, Y 2006, *Identifying the woman, the client and the victim*, Australian Centre for the Study of Sexual Assault, Melbourne.

Lewis, SH 2003, *Unspoken crimes: sexual assault in rural America*, National Sexual Violence Resource Centre, Enola, Pennsylvania

Lovett, J, Regan, L & Kelly, L 2004, *Sexual Assault Referral Centres: developing good practice and maximising potentials*, Home Office, London.

Manderson, L & Rae Bennett, L 2003, *Violence against women in Asian societies*, Routledge Curzon, New York.

Martin, SL et al 2007, 'Health care-based interventions for women who have experienced sexual violence: a review of the literature', *Trauma, Violence & Abuse*, vol. 8, no. 1, pp.3-18.

McGregor, M, Du Mont, J, & Myhr, T 2002, 'Sexual assault forensic medical examination: is evidence related to successful prosecution?', *Annals of Emergency Medicine*, June 2002, vol. 39, no. 6, pp. 639-647.

Migrant Women's Emergency Support Services, Annual Report 2006, p. 9.

National Association of Services Against Sexual Violence 2000, *National data collection project: report on the snapshot data collection by Australian Services Against Sexual Violence, May–June 2000*, CASA House, Melbourne.

National Sexual Violence Resource Center 2006, *Report on the National Needs Assessment of Sexual Assault Response Teams*, NSVRC, Pennsylvania.

Neame, A & Heenan, M 2004, *Responding to sexual assault in rural communities*, Australian Centre for the Study of Sexual Assault, Melbourne.

Nosek, M et al 2001, 'Vulnerabilities for abuse among women with disabilities', *Sexuality and Disability*, vol. 19, no. 3, pp.177-89.

NSW Violence Against Women Specialist Unit 2006, *Improving service and criminal justice responses to victims of sexual assault*, Department of Community Services, Sydney.

Home Office 2008, *Sexual Assault Referral Centres*, Home Office, London, viewed 2 September 2008, http://www.homeoffice.gov.uk/crime-victims/reducing-crime/sexual-offences/sexual-assault-referral-centres/.

Office of Women's Policy 2002, *Acting on the Women's Safety Strategy* , Department of Premier and Cabinet, Victoria.

Olle, L 2005, *Mapping health sector and interagency protocols on sexual assault*, Australian Centre for the Study of Sexual Assault, Melbourne.

Olle, L., D'Arcy, M. & Gridley, H 2004, 'Victim support', *Encyclopaedia of Forensic and Legal Medicine*, Elsevier, Oxford.

Posttraumatic Stress Disorder DSM-IV™ Diagnosis and Criteria, viewed February 2009, http://www.mental-health-today.com/ptsd/dsm.htm.

Queensland Corrective Services 2006, *Assessment, Management and Supervision of Sex Offenders in Queensland*. viewed February 2009, http://www.dcs.qld.gov.au/Publications/Corporate_Publications/Miscellaneous_Documents/SOP%20policy%20paperv5b.pdf.

Queensland Health 2007, *Queensland Statewide Health Services Plan*, viewed February 2009, http://www.health.qld.gov.au/publications/corporate/stateplan2007/.

Queensland Health 2008c, 'Clinical and Statewide Services Division: Role description H08CSS454', Queensland Government, Brisbane, viewed 10 September 2008, http://smartjobs.qld.gov.au/jobtools/b_fileupload.proc_download?in_file_id=6043660&in_servicecode=CUSTOMSEARCH&in_organid=14904&in_sessionid=0&in_hash_key=208B867496A22BD3.

Queensland Health Strategic Plan, 2003-2007. Provided to KPMG by Queensland Health.

Queensland Health, 2007, *A Review of interagency guidelines responding to adult sexual assault*. Provided to KPMG by Queensland Health.

Queensland Health, Information on Statewide Sexual Assault Helpline. Provided to KPMG by Queensland Health.

Royal College of Obstetricians and Gynaecologists – Clinical Effectiveness Unit 2006, *Is there any available evidence on the evaluation of Sexual Assault Referral Centres?* RCOG, London.

Saint-Martin, P, Bouyssy, M & O'Byrne P 2007, 'Analysis of 756 cases of sexual assault in Tours (France): medico-legal findings and judicial outcomes', *Medicine, Science and the Law*, vol. 47, no. 4, pp. 315-24.

Scott, Walker and Gilmore 1995, *Breaking the silence : a guide to supporting adult victims/survivors of sexual assault*, 2nd Edn, CASA House, Melbourne.

Sexual Offences and Community Affairs Unit 2008, 'Annual report 2006/2007 & additional information on 2007/2008', National Prosecuting Authority, Pretoria, viewed 3 September 2008, www.pmg.org.za/files/docs/080521soca.ppt.

Smith, K et al 1998, 'Sexual Assault Response Team: overcoming obstacles to program development', *Journal of Emergency Nursing*, vol. 24, no. 4, pp.365-7.

Sokoloff, NJ & Dupont 2005, 'Domestic violence at the intersection of race, class and gender', *Violence Against Women*, vol. 11, no. 1, pp.38-64.

Surviving Trauma After Rape n.d., *Description of Service*, STAR, West Yorkshire, viewed 2 September 2008, http://www.starproject.co.uk/services.htm.

Temkin J. Medical evidence in rape cases: a continuing problem for criminal justice. Mod L Rev 1998;61:821–48. Cited in Chowdhury-Hawkins, R et al 2008

The State of Queensland 2009, Department of the Premier and Cabinet, viewed November 2008, http://www.thepremier.qld.gov.au/tomorrow/index.aspx.

Thorpe, L, Solomon, R & Dimopoulos, M 2004, *From shame to pride: access to sexual assault services for Indigenous people*, Elizabeth Hoffman House and CASA House, Melbourne

Tschudin, B 2005, 'Immediate care for women after sexual and physical assault', *Ther Umsch*, vol. 62, no. 4, pp.223-9.

Victorian Health Promotion Foundation 2008, Vichealth, Melbourne, viewed February 2009, http://www.vichealth.vic.gov.au/~/media/ProgramsandProjects/MentalHealthandWellBeing/Publications/Attachments/ResearchSummary_VAW.ashx.

Victorian Law Reform Commission 2004, *Victorian Law Reform Commission Sexual Offences: Law and Procedure Final Report*, Victorian Law Reform Commission, Victoria.

Welch, J & Mason, F 2007, 'Rape and sexual assault', *British Medical Journal*, vol. 334, pp.1154-8.

Wilkinson, R & Marmot, M 2003, *Social Determinants of Health*, World Health Organisation, Denmark.

Wilson, D & Klein, A 2005, *An evaluation of the Rhode Island Sexual Assault Response Team (SART)*, Botec Analysis Corporation, Massachusetts.

World Health Organisation 2002, *World report on violence and health*, WHO, Geneva.

World Health Organisation 2003, *Guidelines for medico-legal care for victims of sexual violence*, WHO, Geneva.

E Commonly used acronyms

CALD	Culturally and Linguistically Diverse
CFMU	Clinical Forensic Medicine Unit (part of Forensic and Scientific Services in Clinical and Statewide Services Division, Queensland Health)
FMO	Forensic Medical Officer
FNE	Forensic Nursing Examiner
GMO	Government Medical Officer
IWSS	Immigrant Women's Support Service
SASSP	Sexual Assault Services and Prevention Program, Queensland
SARC	Sexual Assault Referral Centre (UK)
SART	Sexual Assault Response Teams (USA)