



DOCTORS FOR SEXUAL ABUSE CARE

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NATIONAL NEWSLETTER

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From the President - Clare Healy

By the time this newsletter gets to you, we will have held our "Planning Day" at the end of May. The purpose of this day is to review the last 15 years and look ahead to the next 5-10 years, and decide where DSAC should be going. We hope to clarify our aims and core business and adjust our structure accordingly. I would like to thank all who attended the day and others who contributed by sending e-mails or letters.

There have been quite a few things going on to keep the DSAC office busy over the last few months. John Briere's visit was a success with positive feedback from his well-attended seminars. In March, a Basic Adult Forensic Training weekend was held in Christchurch. There were seventeen people attending from both North and South Islands. The Pegasus IPA was kind enough to allow us to use their meeting room and equipment free of charge, for which we are grateful. The highlight of the course was the "mock court session", its impact only slightly reduced by our inability to access the High Court with the security card provided. Nothing daunted, the legal team from the Crown Prosecutor's office offered their library instead and the session was held there. I was impressed with their ability to slip into their roles of prosecutor and defense, to move smoothly from witness to witness and cover all the requested learning points. Despite initial anxiety by most participants, everyone found it an excellent session.

A major task during March and April was the preparation of a submission to the select committee currently considering the Crimes Amendment Bill (no 2). It was necessary to canvas opinion from interested DSAC Doctors, research ideas, enquire about legal points from various sources of advice around the country and then try to put the final thoughts into a sensible document. Thanks is due particularly to Kristen Sorrenson, Rosy Fewicke and Christine Foley, but also to everyone else involved. The final submission is available from the DSAC office for members to access if they wish.

The last eight weeks have also seen the "PMO Training Days". These have rolled out around the country and DSAC Doctors have been invited to attend. Dr Jack Drummond, ex-PMO, hosted them. Various people assisted him for the presentations including Dr David Wells from Melbourne. It was a good opportunity to meet fellow Police Doctors and share opinions.

Following the November RC meeting, a letter was sent to CYFS national office requesting a meeting to discuss, amongst

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other things, the fall-off in paediatric referrals from CYFS social workers. A preliminary meeting was held in Auckland with Patrick Kelly, Craig Smith (from CYFS), Ann Pearl, Jane Moloney and myself. Discussions were held and a further meeting is planned for late May. Another piece of DSAC liaison work has involved Wellington based Dr Kathryn Leslie, working with ACC who are looking at proposals from various groups wishing to develop guidelines for the diagnosis and treatment of mental injury sustained after sexual abuse.

In April I attended a very stimulating conference in Auckland. It was run by ANZATSA (Australia & NZ association for the treatment of sexual offenders). The Auckland "hosts" had decided to call this year's conference "Sexual abuse and Sexual Offending- the Whole Picture". Their aim was to promote understanding and collaboration in successful treatment and prevention of sexual abuse. I found the whole conference very stimulating and particularly enjoyed the preliminary workshop held by Mary Koss about a programme for applying restorative justice in sexual assault crimes (See later summary).

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P.S. The last weeks of May and start of June have been a whirlwind of activities. The planning day was well attended but coloured by the sad news that Claire Hurst's son was recently killed in a road accident in Australia. This was obviously devastating news for both Claire and Bill but also for all of us who know them. We extend our love and sympathy to their family.

The DSAC Executive also accepted the resignation of Jane Moloney with regret but we wish her well in her new position.

We have decided to appoint a short term, three-month "coordinator" position, to start on June 14th, allowing a two-week overlap with Jane. To this end, I am delighted to welcome Hayley Samuel to the DSAC family. She brings a wide range of skills and knowledge and I am sure we will all enjoy the experience of working with her.

All in all, the last couple of months have been action packed and anything but mundane!

Clare Healy, Christchurch

Report from DSAC Librarian Janice Giles

I expect you will have received the most recent mail-out by the time you read this newsletter. It has taken quite a lot of effort to collate recent mail-outs due to the burgeoning supply of potentially relevant abstracts. Abstracts are assessed, and potentially useful full-text articles are sourced and checked before inclusion in mail-outs. This has become quite a lengthy process and resulted in escalating photocopying and bulk mailing costs. We have also received feedback that there is just too much to read.

It is important that the items we are sending are relevant to your practice. A questionnaire is underway to canvas your needs. Your response will help us provide a service that fits your requirements.

Meanwhile, we hope you find the current mail-out useful.

Janice Giles
DSAC Librarian



Journal Club Subscription Fees

Full Journal Club Membership – Adults and Children	\$90
Partial Journal Club Membership – Adults only	\$45
Partial Journal Club Membership – Children only	\$55
Medline Searches only	\$25

Subscribers receive four quarterly mailouts per year.

THE MEDICAL MANAGEMENT OF SEXUAL ABUSE FIFTH EDITION 2002

The DSAC training manual is a resource for medical health professionals who provide medical care for victims of sexual assault. It is a supplement to the DSAC training courses in medical management of sexual assault and represents a collation of current thinking in this field of medicine, from both local and international sources.

The technology of the Web will allow DSAC to regularly up-date sections in response to new knowledge. Users can browse and download in print individual chapters as they wish. The date when each section is updated appears at the top of the section.

The manual consists (416 pages in total) of an introduction, fifteen sections, nine appendices and an index. Visit www.dsac.org.nz

Access to it is by purchasing an individual user name and number through the DSAC office. Annual access fees include GST.

Individual paid-up DSAC Members	- \$30.00	Individual non DSAC Members	- \$80.00
Medical Institution	- \$100.00	Non-Medical Institution	- \$200.00
Hard spiral bound printed copy	- \$75.00		

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With special thanks to Image Centre,
34 Westmoreland Road West,
Grey Lynn, Auckland
(09) 360 5700
for printing this newsletter



Project Co-ordinator's Report

Jane Moloney

Since the last Newsletter:

Forensic Training

After a very successful training weekend in Christchurch that was attended by 17 registrants:-

7 GPs from Christchurch
1 Medical Officer from Christchurch
2 Practice Nurses from Christchurch
1 GP from Nelson
1 GP from Darfield
1 GP from Rangiora
1 GP from Ashburton
1 O&G Registrar from Christchurch
1 O&G Registrar from Dunedin
1 Doctor from Palmerston North

We are now in the final stages of organising the Auckland Forensic training which will be held from Friday June 25th to Sunday June 27th. As mentioned in the last newsletter we increased the geographical distribution of Auckland Forensic training programmes as follows:

Auckland Medlab (2000)
Northland Pathology (100)
Hamilton Medlab (220)
Gisborne Medlab (30)
Medlab Hawkes Bay (130)
Palmerston North Medlab (200)
Taranaki Medlab (100)
Valley Diagnostics (Wellington) (400)

This has brought 28 registrations in from:

North Island:

Auckland (13)
Dannevirke (1)
Dargaville (1)
Hamilton (2)
Inglewood (1)
Marton (1)
Nelson (1)
New Plymouth (1)
Palmerston North (1)
Wellington (3)

We also have registrations from Christchurch, Greymouth and Tasmania. The number of registration has forced a change of venue and the training will now be held in Ferndale House, Mt Albert. Ferndale House is a historic house that belongs to Auckland City Council and we have been successful in our application for a community group discount on the hiring fee.

Ministry of Health Domestic Violence GP Training Contract

The progress of training against the contacted numbers was reviewed at the end of March and the budget compared to actual and forecast expenditure. The current contract will run until the end of March 2005. As some of those originally involved in the project have lost their enthusiasm for training and others are feeling a little overworked and underpaid for their continued efforts it was felt that the budget revision would allow for an alteration to the payments available as follows:

- Retrospective payments were made to all trainers to

acknowledge their hard work and commitment so far. It was hoped that this might encourage those who have dropped out to consider coming back to the job and to ensure we don't lose any more trainers

- Establishment of Koha for key support (non-statutory) agencies
- Ongoing honorarium for trainers doing regional co-ordination
- Payments for assistant trainers
- *It was agreed that a meeting for trainers for updates and support should be arranged for later in the year. This would also provide a forum for discussion on the possible renewal/roll over of the contract for another three years*

Child Protection Training (as part of Ministry of Health Domestic Violence Contract)

As half of the contracted volume of family violence training is intended for Child Protection training for GPs we have moved forward on rolling out this part of the training. Progress so far is:

- We have produced Child Protection folders with Patrick Kelly and sent them out to the nominated Paediatrician in each DHB
- Patrick Kelly has delivered 1 session in May in West Auckland which was well received although feedback indicated that 2 hours is a very short time to cover such a wide range of Child Protection issues
- *This month I will be following up the mail out of the training material with a phone call to the nominated Paediatricians. In addition to trying to motivate them to deliver the training and put them in touch with the CME co-ordinators in their district I will also try to put them in touch with other DSAC trainers and their DHB family violence co-ordinators.*

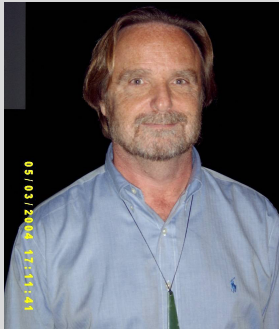
Journal Club

As mentioned by the librarian, a draft questionnaire has been produced which will be sent out in June. The aim is to re-evaluate the service for Adult Journal club (and therefore full journal club) subscribers. The Paediatric Journal club works well and the response to its new format has been overwhelmingly positive.

Finally it is with some regret that I have decided not to continue in the position of Project Co-ordinator with DSAC. I have met some wonderful people in the eight months that I have been with the organisation and have enjoyed working with everyone both in and associated with DSAC during this time. However hard everyone has tried during this time of transition I have realised that I am not happy in the job and need to move on. I wish DSAC and all its members well and hope that the organisation that emerges strong, well and robust from this time of change.

Jane Moloney
Project Co-ordinator 

John Briere Seminar



“Understanding and Treating Severe Relational Disturbance from a Trauma Perspective”

05 March 2004 - Waipuna Hotel & Conference Centre,
58 Waipuna Road,
Mt Wellington, Auckland

Website: www.johnbriere.com

1. Traditional and Modern views: an overview

Briere offers two views of borderline personality disorder (BPD); the traditional view arising from the original term and a more modern view which relates BPD to early relational trauma.

Traditional view: In its original meaning, the term “borderline” defined a group of people who experienced symptoms of both neurosis and psychosis. Neurosis is loosely defined as discrete and acute anxious or depressive episodes, usually associated with ongoing conflictual relationships and personal problems. Neurotic individuals were not considered “deeply mentally disturbed”. Psychosis was defined as the loss of contact with reality. The theoretical cause of this borderline state was a “borderline” mother who had difficulties with boundaries, a need for being taken care of and a fear of abandonment. As a result any attempt to individuate or withdraw on the child’s part, triggered the mother’s fear of abandonment and caused her to withdraw from the child. Such withdrawal by the mother mimicked abandonment, causing the child significant distress. This resulted in attempts to connect with their mother, which was rewarded with closeness and warmth, often at intrusive levels. Thus, over time, a cyclical process of punishment for separation and reward for enmeshment developed. The problem with this theory is that no attempt is made to explain what caused the original “borderline mother” to become a “borderline” individual. Additionally, research into BPD does not support this explanation.

Traditionally, “borderline” patients were seen as manipulative, untruthful and prone to “acting out”. BPD was held to be very hard to treat and had a poor prognosis. Briere suggests that the poor prognosis was a result of inappropriate treatment arising from erroneous theories of the causes of BPD.

Modern view: In the modern view BPD is seen as a reactive response to early relational trauma. Emotional neglect and sexual abuse (CSA), in particular, seem to be closely linked to the development of BPD. Briere suggests that individuals with a BPD diagnosis (or traits) are trauma clients for whom CSA or emotional neglect occurred very early and was more chronic.

2. Attachment Difficulties and DSM – IV – TR criteria for BPD

CSA and emotional neglect have both direct and indirect

sequelae. Indirect effects arise from the impact on parent / child relationships through disruptions to attachment. Attachment disruptions may arise where the abuser is the parent, but also where the child withdraws into himself or herself as a result of abuse or neglect, thereby becoming unresponsive to their parent(s).

Research shows that the consequences of disrupted parent / child attachment include difficulties with:

- (1) affect regulation, tolerance and stability
- (2) a sense of and the valence of identity
- (3) relatedness

Briere revisits the DSM – IV – TR criteria for BPD and notes that when they are deconstructed they fit clearly into these three areas, thereby providing evidence that BPD is related to early relational trauma (see Appendix One for detailed breakdown).

3. Systems that enable the development of core symptoms of BPD from a trauma perspective

Briere identifies three phenomena which are implicated in linking early relational trauma to the observable symptoms of BPD. These are implicit memory, attachment and relational schema.

Implicit Memory

Implicit memory plays an important role in understanding the presentation of BPD. During the first two to three years of life when language is yet to be developed, implicit memory is responsible for recording our learning. Furthermore, implicit memory dominates during times of immense stress.

Implicit memory is mediated by the amygdala, which encodes sensory details particularly those associated with fear or anger. Implicit memories are, therefore, largely motor, experiential and consist of sensations and feelings. What is particularly relevant to BPD is that implicit memories are not able to be consciously retrieved. That is; the individual is unaware that they are “remembering” and is unable to consciously place themselves within the memory (not autobiographical). Thus, a sensation or feeling that is being recalled may be mistakenly interpreted as being produced by the current situation. This source attribution error, is critical in explaining the chaotic relationships typically experienced by individuals with BPD.

Attachment

Briere loosely described attachment as a wired in biological mechanism that is designed to keep a child and its caregiver in

contact. Both the infant and the adult feel distress upon separation; in the case of the child this distress is tremendous. From a behavioural perspective separation is punished. In addition, Briere suggests that the same biological mechanism rewards proximity (or connectedness) through the positive feelings associated with it; that is love. When this system fails, and connectedness is not established between a child and its caregiver, BPD may result.

Relational Schema

During the early development period, beliefs and expectations about the world and others are formed, based on (attachment) experience. Because they are developed in the pre-language period, these relational schema are driven by implicit memory and are comprised of attachment level emotions encoded cognitively. They can be triggered by a stimulus in the environment that mimics the original traumatic relational experience. When these relational schema are triggered the emotions and sensations associated with the schema are not recalled, but re-experienced. This re-experiencing is known as a conditioned emotional response (or CER).

Because the stimuli in the environment for people with BPD is people and relationships with people, their relational schema and CERs are consistently triggered.

4. Phenomenology of activated relational schema

Relatedness:

Because disrupted attachment leads to insecure attachment styles, a preoccupation with relatedness is common. Relationships for individuals with BPD tend to be chaotic as a result of the negative CERs that have developed from early abuse and neglect. These CERs cause the individual to react to relationships with anger/rage, fear/paranoia and hypervigilance. An intense fear of abandonment also colours their relationships. Whilst these individuals crave relationships with or attachment to others they are at the same time afraid of them.

Affect:

Other directedness: In an abuse environment children quickly learn that reality is what other people think and feel. They are rewarded for reading others well, and punished for reading themselves well. For example, acknowledging or recognizing their own anger (let alone expressing it) is not adaptive in such a dangerous environment. This leads to poor affect identification and regulation.

Avoidance strategies: Because emotions associated with abuse are so overwhelmingly distressing to children, it becomes almost impossible to learn affect regulation. This is best learned when small manageable amounts of distress are experienced at discrete intervals. Dissociation becomes one of the few means of coping with emotions. Tension reducing behaviours become common for the same reason.

Identity:

Awareness: The other-directedness which becomes adaptive in abuse situations impacts on identity and self-awareness. It is difficult to be self-aware when survival requires you to be other-directed, or when you look within yourself and find only pain. Tension-reducing strategies and avoidance activities (e.g. dissociation or substance abuse) further reduce self-awareness.

It has been suggested that the sense of emptiness that is sometimes identified by individuals with BPD may be due to a lack of self-reference or identity.

Valence: Individuals with BPD have very strong assumptions and beliefs that they are bad. These beliefs are very resistant to change because they have root in implicit memories. These people learned they were bad before they could talk, and therefore they cannot be talked out of it. The most effective way to treat this is through the way they are treated (i.e. respect, empathy, being heard). Though Briere stated that the therapist "going on record" as believing the client is not bad, is a good idea.

5. Therapy for BPD from a trauma perspective

Once BPD is understood from a trauma perspective, prognosis may be viewed more favourably; difficulties in affect, identity and relatedness are treatable. Briere suggests that his model of treatment for trauma, when appropriately adapted, is one that works successfully for individuals with BPD.

Whereas in trauma therapy the focus is on a specific traumatic experience, treatment for BPD focuses on relationships with others as the "trauma". The treatment involves five main steps:

Exposure

In this case merely engaging the client in a therapeutic relationship provides exposure to the trauma.

Activation

Again the therapeutic window is very important. The aim is to achieve a moderate amount of activation. Over and undershooting this window is very common in BPD, because getting the right amount of titration is very difficult when forming relationships. The therapist must navigate between having too close and too distant a relationship with their client. The therapist is required to be more "in" the relationship than in less complex trauma cases, and as a result the relationship may be activating for the therapist as well.

Disparity

This is the concept of experiencing safety when expecting danger. For individuals with BPD the disparity may be difficult to identify, because of source attribution error. Much of what therapists do (being in relationship with our clients) will trigger relational schema and their associated CERs. Because these cannot be identified as memories, it is natural for the individual to assume the therapist is causing the strong emotions they are experiencing. Thus, identification of disparity is a slow process.

Counterconditioning

Therapy must provide strong feelings of safety and love, in order to be felt through the conditioned emotional responses therapy evokes in individuals with BPD.

Extinction

This occurs because the triggered CER is not being reinforced by the environment. Thereby decoupling the memory from its cognitive emotional gestalt.

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6. Therapists have relational schema too!

Briere replaces the traditional term countertransference with counter activation. He states that therapists typically have hyperaccessible relational schemas around likeability, specialness and effectiveness in therapy. Therapists therefore run the risk of becoming punitive and withdrawing when clients do not like us, or do not get better. However when this happens the client is no longer experiencing disparity, but rather are being re-traumatised.

Briere emphasises that this is not what bad therapists do, but what *therapists* do, and so it is imperative that therapists working with BPD seek their own therapy. At the very least supervision or peer support is required. However Briere commented that it also helps to know that the client distrusting their therapist is due to early traumatic experiences not the therapist themselves.

Appendix One

DSM- IV – TR Criteria for BPD:

(1) *“frantic attempts or avoid real or imagined abandonment”* – Briere relates this to disruption in attachment relationships as a result of neglect and abuse, leading to insecure attachment styles, including preoccupation with connectedness.

(2) *“a pattern of unstable and intense interpersonal relationships”* (e.g. idealisation, manipulation, and marked shifts in attitude). – Briere suggests that this arises from difficulties with affect regulation. The idealisation / devaluation cycle arises because the client wants to believe that this relationship will be the redemptive relationship. When the individual proves to be human, they feel as though they have been betrayed and lied to.

(3) *“identity disturbance: markedly and persistently unstable self image or sense of self”* – again related to disruption in attachment relationships as a result of neglect and abuse.

(4) *“impulsivity in at least two areas that are potentially self damaging, (e.g. spending, sex, substance use, reckless driving, binge eating)”*. - Briere states that these are mostly tension reducing behaviours (TRBs) which become methods of dealing with the pain that is triggered through relationships with others, Due to early trauma preventing the development

of emotion regulation or tolerance skills, individuals with BPD have no other means of coping with the pain and distress that arises when their relational schema are triggered. Unfortunately these TRBs are self-perpetuating because they do not resolve the distress and often create more.

(5) *“recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour”* -Briere argues that these are not a unitary construct. He suggests that qualitative or anecdotal evidence suggests that self-mutilating behaviour is another form of TRB, whilst suicidal behaviour, gestures or threats are a means of connecting with others.

(6) *“affective instability due to a marked reactivity in mood”*. - These are related to attachment disruption through difficulties with affect regulation and tolerance. The other directedness that results from early abuse also impacts here as it has been adaptive to allow external cues to regulate their emotional states.

(7) *“chronic feelings of emptiness”* – there are three possible explanations for this. 1) A lack of a sense of identity, or 2) due to the difficulties with connectedness with others, which Briere suggests we all search for all of the time, or 3) a symptom of depression.

(8) *“inappropriate, intense anger or difficulty in controlling anger”* - Briere states all abused children feel angry yet in abusive environments withholding anger becomes necessary for survival. Thus there is a great deal of anger that is not resolved. When this anger is triggered, it may seem out of proportion to the given situation or of extreme intensity due to both the re-experiencing (source attribution error) and the difficulties with regulating emotion.

(9) *“transient, stress-related paranoid ideation or severe dissociative symptoms”* – paranoia may be due to psychosis, people may really be out to get them, or the relational schema that has developed as a result of the early abuse leaves them believing that people are out to get them. Dissociative symptoms are a major symptom of PTSD. They also serve as a defensive mechanism since alteration in awareness may reduce distress.

Luci Falconer,
Post Graduate Psychology Student,
Auckland University

A seminar for medical emergency response teams.

Visiting Guest Speaker: Professor John Briere, Ph.D

“Addressing the Hidden trauma”

Minimising the long term impact of acute psychological trauma.

When: 9.30am to 11.00 am Thursday 26th August 2004

Where: Marion Davis Library Auckland Hospital . Park Road. Grafton

Cost: \$20.00 payable at door

Seminar open to all Emergency Departments and Trauma Service Staff in the Auckland District health Board, Counties Manukau District Health Board and Waitemata District Health Board. Pre registration is not necessary and the \$20.00 fee will be collected at the door.

ESR Update - March 2004

ESR invited DSAC members in Auckland to their Annual Forensic Client Function on 18th March 2004. This was very well attended by police and lawyers. Meeting face to face some of the scientists we have had extensive telephone and email contact with was invaluable. Kristen and Christine took the opportunity to further discussions regarding doctors accessing ESR results and receiving constructive feedback re MEK performance.

We were treated to an interesting update on new forensic techniques and a summary of recent trends in the areas of toxicology and drug testing

DIGITAL IMAGING

By running an Image Enhancement Programme on digital photographs one is able to highlight certain parts of the image by selecting specific wavelengths relating to that part of the image. Examples where this is particularly useful were illustrated such as : blood or semen staining on clothing allowing the scientist to more accurately identify which parts of the clothing to test; fingerprints or shoeprints that are only partially visible due to say a dark object that they are on ,thus allowing an image of the complete print. There is still considerable validation testing to complete and obviously the original image must be saved prior to any manipulation.

ESR are also using digital imaging to more accurately identify patterns left by tools or weapons.

TABLET COMPUTERS

These are now in use at many crime scenes. They allow the scientist to handwrite directly onto the screen (this is then automatically translated to type). Particularly useful for immediately downloading a photo of a scene or an exhibit and adding notes to it rather than having to sketch or draw diagrams.

DRUG TRENDS 1999-2004

ESR's figures for analysis of drugs requested by Police reflects the drug use trends in society

There has been a huge increase in the amount of methamphetamine being processed by ESR, in the last 5 years and the number of clandestine labs (p manufacture "cooking") being detailed. Total of 9 laboratories in 2000 to more than 200 in 2003. The %purity of p has also increased from an average of 5% 1999-2000 to >70% 2003-2004.

Y CHROMOSOME ANALYSIS

This is a new service now on line at ESR. This involves running a DNA profile of the Y chromosome. This gives only one peak on the DNA graph as there is only ever one Y sex chromosome (cf the autosomal pairs currently used). The Y chromosome is passed from father to son essentially unchanged. It has a unique structure and very few genes. The resultant profile is called a YSTR Profile.

This may be useful in cases where

- There are low levels of male DNA and high levels of female
- There is a mix of DNA from multiple males
- Family relationships require elucidating eg: missing persons
- Prediction of ethnicity (strong ethnic correlations with certain Y profiles)

Requires caution with interpretation and has low levels of discrimination so the "numbers" are low –in the 1:200 compared to 1:millions we are now seeing with routine DNA profiles. No national database to compare profiles against.

ISOTOPE TESTING

ESR can now look at traces of a substance and by identifying the actual isotopes of chemicals present identify the likely source of that substance. E.g.: that a drug found on a user is isotopically identical to that of a dealers supply; identify more accurately where geographically a plant sample has originated from.

DRUG FACILITATED SEXUAL ASSAULT

Diana Kappatos presented a summary of toxicology results from June 2001-2003 which validates our experience clinically, and that of Dr. Kristen Sorrenson's audit of Pohutukawa cases. That is that ALCOHOL is the number one drug, a high percentage of screens are negative for any drug, and positives for other drugs are rare.

Also presented a summary of a 100 consecutive recent sexual assault cases.

- Predominantly a young age group
- Most histories included memory loss
- Time lapse to specimen collection a continuing issue-52%>15 hours
- Alcohol the number one
- Amphetamines found in 9/100

Other Comments

- Ecstasy MDMA or the "love drug" induces feelings of wanting to be touched and loved. Detection limit in blood 18 hours and urine 2-3 days.
- Phenomenon of tolerance to alcohol makes the prediction of level of intoxication from serum levels difficult. In contrast memory loss or gaps is not affected and is usually present at levels of 250 mg% or more
- THC may enhance the effect of alcohol
- Analysis of hair samples is in development
- In the future the window periods for drug detection may be increased with tests being developed for the metabolites of substances.

Kristen Sorrenson
DSAC Doctor, Auckland

IMA Training

I attended an ACC training session to become an initial medical assessor for Sensitive claims on 12th March, along with 3 other doctors from around the country. James du Plessis facilitated the meeting, and we were introduced to Peter Turnbull (Case manager).

There appears to be a back log of ACC clients on weekly compensation, who have not been reassessed on their ability(or inability)to return to the workforce. Denise Udy gave a general outline on vocational rehabilitation, which was instructive and clear. Blair Christian is a psychiatrist who is clinical advisor to the Sensitive Claims Unit; he outlined the format for performing the assessment, and what was required of the assessor. He was keen for us to communicate with him if we had any queries.

The Assessment entails:-

1. Take a detailed history of the assault and how this affected the patient.
2. Assess the patient's current physical and mental status.
3. Take a medical history including current treatment and general health.

4. Read all the reports from ACC GPs, psychiatrists, counsellors etc.
5. Go through all the types of work identified in Initial Occupational Assessment with the patient, and comment on the suitability for that individual.
6. Make a final statement, collating all the information. The interview may take up to 2 hrs, and one of the doctors already performing the assessments takes several hours to go through the information, and dictate her report.

Details of the contract can be obtained from ACC.

I have yet to perform an assessment; however, I think that DSAC doctors are in the best position to perform a sensitive and well thought out report.

Will keep you posted.

Clare MacGougan
DSAC Doctor



Jackie Pivac, the new ACC Sensitive Claims Unit Manager is very happy for DSAC Doctors who want to, to receive a copy of the regular newsletter that Sensitive Claims Unit sends out to all counsellors. This seems like a good way for DSAC doctors keeping in the loop of what's happening in the counselling world. If you would like to receive an emailed copy of this newsletter, please contact Jackie Pivac at ACC: jackie.pivac@acc.co.nz

SCAG: Sensitive Claims Advisory Group

SCAG or Sensitive Claims Advisory group was set up by ACC as a multidisciplinary group to advise on current ACC sensitive claims issues . It covers the claims' assessment/ evaluation and ongoing reports involved in the continuation of cover for people utilising this care.

The group consists of representatives from: NZAC (New Zealand Association of Counsellors), NZACP (NZ Association Child Psychotherapists), Social workers, DSAC, RNZCGP (NZ College of General Practitioners), NZMA (NZ Medical Association), NZAP (NZ Association of Psychotherapists), Clinical Psychologists, NZ Psychological Society, Psychiatrists, Maori.

Kathryn Leslie is the RNZCGP representative and Ann Pearl is the DSAC representative.

Jackie Pivac is chairing the meetings as manager of Sensitive Claims Unit. The group meets every 3-4 months approximately.

Recently a proposal for "Guidelines for the diagnosis and rehabilitation of mental injury in survivors of sexual abuse" has been selected. This is funded by ACC and will be available to all those involved in this work throughout NZ. It is likely to be completed by late 2005.

SCAG will be one of many groups that will be requested to have a collaborative/advisory input into this large piece of work.

Kathryn Leslie
DSAC Doctor, Wellington

ACC UPDATE

Jane Moloney and Kristen Sorrenson met with James Du Plessis on March 18th to progress some of the issues DSAC raised with ACC last year. This was a productive meeting.

DSAC Manual Section 12

The latest re-write of section 12 of the DSAC manual had been circulated to ACC for comment and feedback. They had reviewed the changes and agreed with only some minor amendments. So the new updated chapter 12 will be available on the website soon.

A few of the important amendments that ACC clarified are:

- Reminder that the code SN571 can still be useful for lodging a claim. It is not a diagnosis per se of mental injury.
- Also discussed the fact that Significant Physical injuries incurred in the context of a sexual assault are still to be lodged separately using a separate ACC45 (as per section 12.2.7 of the manual) This may in fact change again, in the future to them all being managed at the SCU.
- Counselling – Payments have gone up to \$76.50 per hour for counsellors and \$97.55 for psychiatrists. [Please note that these payments include GST.]

We discussed the fact that the GP's guide to completing the ACC45 has omitted the diagnosis of Acute Stress Disorder (**EU 430**) in the list of common sexual abuse Read Codes.

Payments under the DSAC Sexual Assault & Management Contract

James acknowledged our application for price review as per letter written by DSAC 14.01.04. This letter included a request for all initial Child and Adolescent examinations being able to be invoiced at the "acute" rate (acknowledging the amount of time and work involved), a request for more than one follow up visit and the inclusion of a non-attendance fee. The application will be consulted on internally before going to the Purchasing Committee for consideration.

New Amended ACC 1276 (including new DASA section)

ACC have re-drafted the ACC1276 form to accommodate clarification WRT whether the form is just being submitted in order for DSAC doctor to get paid or whether it is for cover. And also to prompt doctors to provide the information

needed in Drug/alcohol Assisted sexual assaults.

Also a new form "Claimant authority for Alternative Postal Address" has been developed to get around the legal requirements, when the patient doesn't want their home address put on the ACC 45.

These forms have been circulated to the executive and Regional coordinators for comment.

ACC1277 forms

If ACC approves the new funding for further visits we may need to file these reports for subsequent follow-ups.

Please could doctors remember to review/update the diagnosis when doing follow up reports.

Crisis Counselling

We took the opportunity to further advocate for funding for Crisis counselling/support services and discussed the possibility of this being funded as an ACC contract. There needs to be a way that all areas of New Zealand might have access to crisis support for acute sexual assault medical and forensic examinations. This is considered a fundamental component of sexual assault care, yet it is variably funded around the country and mostly not funded at all. (There is a current issue regarding the crisis support service in Auckland that we did not specifically discuss at this meeting.) ACC will explore some options and has asked for a formal letter to ACC regarding our opinions about this.

What will ACC cover under the mental Injury cover?

We have still not received a response from our letter written to David Rankin 14.01.04.

Other interesting ACC Developments

Psychiatrists now under contract so can assess (high impact) patients hopefully without need for co-payments.

ACC is also developing a contract for treatment for patients with drug and alcohol problems so that these can be addressed as part of treatment of sensitive claim. In general ACC are trying to address issues that may impede rehabilitation.

The Sensitive Claims Unit has a new manager, Jackie Pivac.

Kristen Sorrenson
DSAC Doctor

Azithromycin

Remember that supplies of Azithromycin (Zithromax) are available for STI prophylaxis for any patient who is at risk of infection as a result of a sexual assault. The regime is absolutely simple 1G. stat. (2 x 500mg tabs)

PHARMAC is fully subsidizing this drug through DSAC and supplies are available from:

DSAC National Office

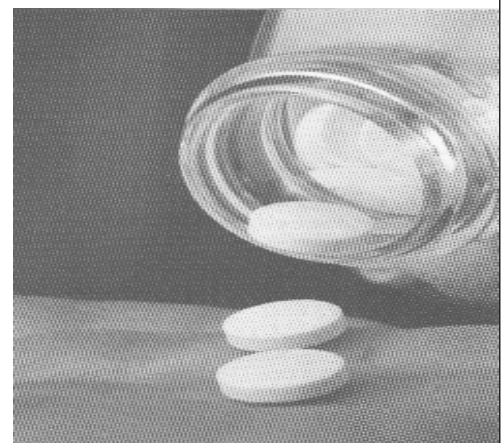
PO Box 90723

AUCKLAND

To order your supplies for the next 6-12 months you can either write,

email: dsac@ihug.org.nz, or

fax: 09-376 0790



The Place Of Restorative Justice In Sexual Crimes



This article will attempt to share some of the information given by Prof Mary Koss in her workshop at the ANZATSA conference in April. [Notes taken during Judge McElrea's talk during the same conference supplement her information].

Some people may remember Prof. Mary Koss's attendance at the 1996 Rape conference. I had heard of her and was inspired and enlightened by her contribution to the 2004 ANZATSA conference. Coming from a public health background, she firmly put sex crimes into the arena of public health issues and suggested some good ideas to promote this theme. However, in this article, I wanted to describe her current work "RESTORE", which is a pilot project implementing a restorative justice programme for selected sexual crimes in Arizona, USA.

Prof. Koss acknowledged that New Zealand has been a world leader in such programmes but that the NZ processes are commonly held pre-sentencing or pre-release rather than *instead* of a trial, as in the Arizona project. Also, in NZ, these processes have not been used for sex crimes.

Just to set the scene, I will try (with reference to Judge McElrea) to explain the concept for those of you who are, like me, unfamiliar with it. The current NZ system for dealing with sex crimes can be a humiliating, traumatic and a potentially re-victimising experience from the complainant's point of view, to the point where most prefer not to go to the Police with a complaint. The predominant focus is to prove guilt, rather than making things right for the victim and wider community. It also does little to address any treatment of the offender.

Prof Koss stated that many women don't want their offender to go to prison, but do want them to get help and to be held accountable. This brings us to the concept of restorative justice which may be a better way to deal with some sex crimes. Restorative Justice describes all the different ways of dealing with wrongdoing by trying to deal with both the causes and the consequences of the wrongdoing.

It aims to move beyond condemnation and punishment. From a Public Health Perspective it addresses Primary, Secondary and Tertiary Prevention in the one process. It tries to promote accountability, healing and justice and can be used in many different settings [school, home, businesses, and the judicial system]. Several different formats can be used depending on the circumstance; victim-offender dialogue, family group conference, community panels etc.

RESTORE is an innovative application of the community conferencing model of restorative justice applied to some sex crimes. RESTORE begins with an investigation

process, which follows standard procedure of collection of evidence. In Arizona, the police process goes up to the point of "Is there a case to answer?" Then further investigation is done by Prosecutors who take over the case at that point. Prosecutors assess cases as to suitability for the RESTORE process (first time offenders, minimal violence, victim in agreement to process and offender then offered process).

First, the victim is informed of the risks & benefits of the process and consent is obtained for referral to RESTORE. The process is then offered to the perpetrator. It takes 4-6 weeks from initial complaint until the prosecutor discusses options with the victim. There is then a 10 day deciding time followed by up to three months of conferencing with the victim and the offender (separately). Both parties are then invited to attend a facilitated meeting, which also includes members of their families and the wider, affected community.

The victim tells her story and the family and friends are invited to describe how the offence against her has impacted on their lives. The perpetrator is then invited to acknowledge and respond to what has been said. A redress plan is presented [having been developed during prior meetings]. It may include such things as an apology, payment of medical and counseling expenses, community service etc.

Agreement is reached between the victim and perpetrator as to redress required. A community board oversees this implementation and monitors the offender for a further year. The expected benefits include earlier accountability in offender "careers" and improved recovery outcomes for victims who feel "heard". Full information about the programme can be obtained from:

<http://restoreprogram.publichealth.Arizona.edu>

This system appealed to me as a process, which may have a place in New Zealand. It may improve outcomes for victims and perpetrators who are "failed" by our current system. It may give more confidence to victims in reporting assaults and to Police, when investigating them, to know that the likely outcome may have a greater positive benefit for both parties.

Certainly it may be better than the current adversarial trial and possible imprisonment, for some offences. The whole topic gave me much to think about and possibly act upon.

- What more could one ask from a conference!

Clare Healy
DSAC President, Christchurch

Report on the Police Medical Officers Study Days

Wellington 20/03/04, Christchurch 21/03/04, Auckland 30/03/04 and Dunedin 25/04/04

Combination of reports by Janet Say, Kathryn Leslie, Penny Kagan and Marie Burke

These study days were very interesting as they covered work DSAC doctors rarely do but are within the bounds of the Police Medical Officers. They included Disaster Victim Identification, the story of the methamphetamine (P) laboratories as well as excellent input from Professor David Wells, Monash University, Department of Forensic Medicine on Non Accidental Injuries in Children, Child Sexual Assault and preparation of Medical Depositions.

All were impressed by the presentation of Jack Drummond who talked about the Police situation. New Zealand has 12 Districts, 3 in Auckland which stretches from Port Waikato to Maungawhau. There are 740 staff and \$53 million to cover the cost with 450,000-500,000 calls a year. In NZ, Auckland takes a third of resources. 60% of under reported crime is Asian. Violent crimes increased by 16%. Auckland has the highest per capita car ownership in the world – 1 car for every 2 persons. Road casualties were up 4% per year. The crime solving rate was 40% overall, 53% in Auckland.

Dr Howard Mace in Auckland and Jules Keiser in Dunedin spoke on dental identification - mostly used for disaster or victim identification but they also spoke on bite marks. There was interesting information on how dental records were used to identify the victims in the Erebus disaster. They talked about Bali and how dental records are important for the early identification process, although DNA is now also being used where possible. Dr Mace also mentioned that *Streptococcus salivarius* strains were very individual and DNA typing could be done for identification,

whether this could be used forensically taking cultures for *salivae Streptococci* is another issue?

Auckland then had Dean Duffy and Dunedin Richard McPhail who spoke about Disaster Victim Identification and the systems in place around NZ through the Police Search and Rescue Organisations. Forensic pathologists, communications personnel, Police, a dentist, radiographers, morticians, and biologists are involved.

Each area had an excellent overview of the use of DNA typing and collection of specimens from the ESR who described how they run their DNA database. Cervical swabs can give positive DNA for 7 to 10 days but anal ones 48 hours, oral swabs may last 12 to 36 hours. Attendees were reminded of the importance of gloves when examining and collecting samples. To collect DNA from skin two swabs should be used – one wet, one dry, then put into the swab containers without medium and with the ends clipped to allow air drying – making a slide of these samples is not helpful.

There followed fascinating stories of the methamphetamine laboratories from Police Officer Sergeant Phil LeComte in Auckland and Kevin Anderson in Dunedin. Most were horrified by the number of laboratories (and cooks baking amphetamine) discovered over the last year and to hear that some of them were booby trapped to catch any Police invasion. If you suspect you have encountered an illegal laboratory do not touch anything as the chemicals are very toxic.

RNZCGP CME Providers Workshop in Wellington on 13/03/04 – Feedback from Clare MacGougan who attended on behalf of DSAC

The Friday night session consisted of a lot of theorising (I think it's also called brain storming, but my brain was in very calm waters !!) So—it was a bit of a drag for me.

Saturday was much better with Mark Shaw presenting. As luck would have it for DSAC—the main thrust of a 2hr session was based on the Patricia Paniana case, who was murdered by her husband. The title of the session was “The use of emotion as a tool for identifying GP learning needs.” We had to discuss and do role-play etc. It certainly raised awareness. A few of the attendees said it was difficult getting GPs to attend the session in the first place (perhaps because it is emotive). I can't say that I contributed much more than anyone else, apart from when we split up into groups, but Mark gave us a few clues about interactive learning.

Even though there are still a significant number of GPs who

say they much prefer formal lectures—it's often because they feel anxious about interactive learning. When it comes down to roleplay—he advises that each group decides between themselves what the plot is going to be, so that the person playing the doctor doesn't feel too threatened if he/she gets stuck or talks drivel. Breaking the session up, so that they don't get bored is also essential, and asking direct questions of the audience regularly (and always validating their point in some way even if it's rubbish!)

I introduced myself to a few people, but wasn't asked about DSAC issues or domestic violence intervention training per se. It didn't seem to be appropriate to hand out the flyers. So all in all, I was a small player.

Clare MacGougan
DSAC Doctor, Nelson

DSAC Diary of Events 2004

DSAC is a RNZCGP CME Registered Special Interest Group

DSAC Forensic Training Weekend
Medical Management of Sexual Assault
Adult & Adolescent

CHANGE OF VENUE

Main Room
Ferndale House, 830 New North Road
Mt Albert, Auckland
25-27 June 2004

Friday evening to Sunday Midday

DSAC Advanced Paediatric Training
and 2nd Combined Australia and New
Zealand
Meeting on Medical Assessment of Sexual Abused
Children and Adolescents
Special Guest Speakers:

Dr Astrid Heppenstall-Heger

Dr John Read

VENUE: Wellington School of Medicine & Health
Sciences,
Mein Street, Newtown, Wellington

DATES: 30 July - 01 August 2004 (3 days)

Visiting Speaker **Babette Rothschild, MSW**

Part One: "The Mind and Body of Trauma: Understanding Traumatic Memory and PTSD"

Part Two: "Making Trauma Therapy Safer: Applying Theory to Practice"

DATES

Christchurch - 08-09 July
Wellington - 12-13 July
Auckland - 21-22 July 2004

VENUES

Christchurch - The Ballroom, Centra Hotel, 2nd Floor, Cnr Cashel & High Sts, Christchurch

Wellington - Theatre Room, Kingsgate Hotel, 355 Willis Street, Wellington

Auckland - Ellerslie Convention Centre, Goldstar Room, 80-100 Ascot Avenue, Ellerslie, Auckland

For all events Apply to:

DSAC National Office PO Box 90 732, AUCKLAND,
5/4 Warnock Street, Grey Lynn, AUCKLAND
Tel: (09) 376 1422 Fax: (09) 376 0790
email: dsac@ihug.co.nz

Visiting Speaker **Mary Harvey, Ph.D**

1-day Workshops

"An Ecological Framework and a "Stages by Dimensions" Approach to Treatment

DATES

Auckland - Tuesday, 14 September 2004
Christchurch - Wednesday, 29 September 2004
Wellington - Friday, 01 October 2004

VENUES

Auckland - Waipuna Hotel & Conference Centre, 58 Waipuna Road, Mt Wellington

Christchurch - Rolleston Lecture Theatre, Christchurch School of Medicine, Chch Hospital, Riccarton Road

Wellington - Theatre Room, Kingsgate Hotel, 355 Willis St

Visting Guest Speaker **Professor John Briere, PhD.** "Addressing the Hidden Trauma"

for Medical Emergency Response Teams

Thursday, 26 August 2004 - 9.30 am - 11.00am

Marion Davies Library, Auckland Hospital, Park Road, Grafton

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