DOCTORS FOR SEXUAL ABUSE CARE

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NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL ISSUE No. 64 SEPTEMBER 2005

From the President - Carol Shand

This is the last newsletter while I am President. It has been a busy three months lobbying again for health sector funding and support for sexual assault medical services, made more urgent by the withdrawal of support for the Auckland after-hours sexual assault roster by the Auckland District Health Board. The experience for DSAC since its inception has always been two steps forward and 1.5 backwards.

Hayley's Manager's Report (see next page) details the events – in particular the submission to the CEOs of Health, Police and ACC. We publish the submission full on pages 8 and 9 with the hope that you may find it useful to assist in lobbying locally for provision of sexual assault services.

The meeting with the Ministry officials, Police and ACC was useful (see Manager's report). We were encouraged by the support from ACC and the Police and the interest expressed by ACC for taking on full responsibility for funding sexual assault medical services. I believe that real progress can be made towards ensuring provision of services nationally as a result of this meeting. However we have yet to receive a formal response.

I am as usual grateful for the continued support of Hayley and the team at the national office. They are the spine of DSAC and without them we would struggle to achieve anything. It is sad to be losing Sara and we wish her well with her new venture into motherhood. I have particularly enjoyed working with Sara on the newsletters which have become her special project and this issue is a tribute to her experience and expertise. Sara has agreed that she is open to DSAC approaching her for assistance on any projects so we hope not to lose her completely. Dee Vorster has joined the team and any of you who have rung over the last few weeks will have heard her as the new voice of DSAC. We welcome her to the team and look forward to working with her over the next few months.

As usual Claire Hurst has a new programme of visiting speakers lined up for us extending into next year and the year after as planning has to be done a long way ahead.

The election campaign will have been impinging on your conscience and consciousness as much as mine. We had an email from Kim McGregor informing us that Labour have accepted a commitment to resourcing sexual assault services and the following is now official labour policy.

"Labour will:
Develop youth specific education programmes, delivered by peers and trained educators, and ensure that the quality of sexual education in schools is monitored with a commitment to continued improvement".

Ensure there are sufficient and well resourced crisis services for victims of childhood sexual abuse, domestic violence, and sexual violence including date rape and rape within relationships and marriage, and ensure there are sufficient and well resourced treatment services for victims and offenders"

If Labour are re-elected we will have to ensure they keep their promises.

Carol Shand, Wellington

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Manager's Report

Hayley Samuel

We will be very sorry to farewell Sara on the 13th September but wish her well for the arrival of her baby boy due on 26th October 2005. Sara's commitment over the last 4 1/2 years with DSAC has been extremely highly valued (words do not do our appreciation justice!). In my time with DSAC I have felt enormously supported by Sara and assured that whilst I was not in the office, Sara was there as the voice of DSAC, ensuring the smooth running of DSAC's daily administrative tasks. Thank you Sara!!

Meanwhile, I am delighted to welcome Dee Vorster, DSAC's newly appointed PA/Administrator, who started with DSAC on Monday 15th August. Dee joins us on a 1-year maternity leave contract with a background in medical administration. Dee, along with her husband, only recently arrived in New Zealand from South Africa and is presently undertaking the process of applying for New Zealand residency. I am very much looking forward to continuing working with Dee. Those of you who will be attending the AGM/Regional Liaison Doctors' Meeting in November will have the opportunity to meet Dee then.

1. Auckland Adults' After Hours Sexual Assault Service

The recent threat by the Auckland District Health Board to withdraw its support for the Adults' After Hours Sexual Assault Service has caused enormous concern for us all as the Auckland Service has long been considered a national 'model' in Sexual Assault Service Provision. A meeting between the ADHB Funding and Service Planning Manager, Trevor Brown, and the Auckland After Hours Rostered Doctors (as represented by Faye Clark and Min Lo), and the affected stakeholders namely: Bruce Shadbolt, Steve Rutherford and Sue Schwalger (Police), Carol Shand and Hayley Samuel (DSAC), Ngaire Garland (Auckland Sexual Abuse HELP), Gaye Hill and Linda Ngapera (Counselling Services Centre), Kristen Sorrenson (Pohutukawa Clinic), Murray Reid (Sexual Health Services) and Patrick Kelly (Te Puaruruhau) was held on Friday 26th August. This gave the ADHB further opportunity to hear the concerns regarding the Auckland After Hours Service – namely no current after hours access for the Auckland Rostered Doctors to the adult facility - and limited funded daytime support for this service. The Auckland After Hours Rostered Doctors requested a written response from the ADHB provided within four weeks from the date of the meeting.

2. Ministry of Health Submission

DSAC sent out a submission regarding a request for a National Inter-Agency Policy for Sexual Assault Services on Monday 1st August to Dr Karen Poutasi, Director-General of Health; Garry Wilson, Chief Executive, Accident Compensation Corporation and Rob Robinson, Commissioner of Police.

The creation of this submission was largely catalysed by the threat to the Auckland Adults' After Hours Sexual Assault Service, but has also been sitting on the to-do list for the DSAC Executive for sometime now. Circulation of this submission resulted in the National Police co-ordinating an inter-agency meeting to discuss the problem and was held in Wellington on Tuesday 30th August with the following people in attendance: Drs Carol Shand and Min Lo representing DSAC, Peter Marshall (Police), Colin Feek (MOH) and David Rankin, Elaine Elbe and Julie Barrow (ACC). The MOH and ACC representatives undertook to come to an agreement as to which of them will be the funder for sexual assault services. They agreed to report back to DSAC within 2 weeks. If the outcome is that the MOH is the primary funder, they can continue to fund DHBs to provide sexual assault services through the sexual health contracts and DSAC would need to lobby very strongly to ensure that these services are delivered throughout New Zealand. However it is more likely that ACC will accept responsibility for funding all sexual assault services. In this instance, DSAC-trained doctors as the service providers, will need to do some active lobbying to ensure that a clearer funding stream results in more adequate provision of medical services for victims of sexual assault. This can either be through DHBs, or through private providers. DSAC's role will continue to be that of a professional organisation supporting its members and encouraging the provision of quality sexual assault medical services easily accessible to all victims of sexual assault.

3. DSAC National Overview Survey of Sexual Abuse Care

Many thanks to those of you who completed and returned the DSAC National Overview Survey of Sexual Abuse Care which was sent out in February. Of the 185 current DSAC Members who are medical doctors, 60 doctors completed and returned the Survey. These returns, in addition to local knowledge, allowed a fairly complete picture of national sexual assault service provision to be assembled. The following statistics may be of interest to you.

- 97 doctors (including back-up doctors) are currently performing sexual assault/abuse exams (NB. This figure does not include all Police Medical Officers performing the exams)
- 87% are DSAC Members
- 13% are non-DSAC Members
- 37% of the doctors have **current** accreditation
- 15% have **lapsed** accreditation
- 53% have **never applied** for DSAC Accreditation

The common issues noted on the returned surveys included:

- Too few doctors doing the work
- Inadequate facilities/funding
- Need more trained nurses
- Need some commitment from Paediatricians to perform the child sexual abuse exams
- Difficulty organising peer review
- No on-call payments for doctors
- Lack of liaison with crisis counsellors
- No CYFS referred suspected child sexual abuse cases
- No DHB support

A letter has been sent out to all non-DSAC Members currently performing sexual assault/abuse examinations inviting them to become DSAC Members and to apply for DSAC Accreditation. I feel encouraged that by having more personal contact with the doctors involved in this work that we will be able to forge an even more steadfast organisation.

4. Ministry of Health – Family Violence Prevention Contract – 1st April 2005 – 30th June 2007

A new Family Violence Prevention Contract with the Ministry of Health has been drawn up (after consultation with the key DSAC Family Violence Intervention Trainers) and signed off. Over the period of the completed contract (1st April 2002 – 31st March 2004) the attendance figures for the workshops were as follows:

Total Attendance to Date – Child Abuse Intervention - 450
Total Attendance to Date – Partner Abuse Intervention - 1502
Total Attendance to Date - All - 1952

Total Numbers of Workshop 1 to Date - 69
Total Numbers of Workshop 2 to Date - 32
Total Numbers of Workshop 3 to Date - 1

Total Number of GPs trained - 945
Total Number of Practice Nurses trained - 556
Total Number of Sexual Health Staff trained - 77
Total Number of Obstetrics & Gynaecology Staff trained - 42
Others - 332
TOTALS - 1952

Note: The attendance numbers recorded above represent the number of individuals who attended **a** workshop i.e. they may have attended all 3 workshops and have therefore been counted 3 times.

5. Criminal Law Committee Meeting – 29th July 2005 - Wellington

Dawn Elder, Patrick Kelly and Carol Shand met with the New Zealand Criminal Law Committee on July 29th in Wellington as a result of the LawTalk article published last year. At this meeting Aaron Lloydd (Secretary to the New Zealand Criminal Law Committee) reported that there had not been a significant number of complaints after the request for lawyers to write in with concerns about "DSAC doctors" as expert witnesses at the end of the original LawTalk article. In fact it was reported that a number of lawyers had written in to say that they had not experienced any problems with DSAC doctors. It was agreed at this meeting that DSAC would provide the New Zealand Criminal Law Committee with a list of DSAC-trained doctors who have indicated that they are willing to provide an expert opinion for the defence. For those of you who are happy to do so, can you please contact the DSAC office and provide your preferred contact details for defence counsel to contact you on.

6. Medical/Forensic Management of Sexual Assault (Adults and Adolescents) - 29th - 31st July 2005 - Wellington

17 people attended this training course as follows:

Napier	-	GP & Police Medical Officer
Wellington	-	Registrar
		Sexual Assault Roster Nurse
		Practice Nurse
Auckland	-	GP
Doctor		
Whangarei	-	GP
		Registered Nurse
Hamilton	-	Practice Nurse
Rotorua	-	GP
		Paediatrician
Taupo	-	GP
Christchurch	-	GP
		2 Registered Nurses
Blenheim	-	GP
Nelson	-	House Surgeon
Timaru	-	Emergency Doctor
Greytown	-	GP

The course was successfully co-ordinated by Jane MacDonald and Kathryn Leslie receiving very positive feedback and a rating of 4.7 overall. Many thanks to Jane and Kathryn for all of their hard work and for maintaining a very relaxed and open environment throughout the training course. The attendees were an enthusiastic and quite experienced group of people, a few of whom I have approached as being possible DSAC Regional Liaison Doctors in their regions. Watch this space!

7. Pharmac Submission

Pharmac formulated a proposal relating to the availability of azithromycin, ceftriaxone and ciprofloxacin on Practitioners Supply Order which was forwarded onto us by Pfizer. Pfizer are unsure at this stage as to whether or not this proposal may affect DSAC's present arrangement with them with regards to azithromycin supplies. Drs Janet Say and Carol Shand prepared a submission on behalf of DSAC which was submitted to Pharmac prior to the closing date.

8. Peer Review Teleconference Trial

At the Education Sub-committee meeting Penny Kagan volunteered to co-ordinate a trial peer review teleconference for doctors who are current DSAC Members working in isolation around the country and who have difficulty arranging peer review. This 1-hour teleconference will be held on Wednesday, 19th October 2005 (DSAC will be meeting the cost). In order to keep the teleconference manageable (both in terms of cost and practicality) we will be limiting the number of people on the conference call to 5-7 doctors with cases for review and 2 'expert' doctors to provide opinions/advice. If there is a large amount of interest in enrolling for this teleconference then we may offer two teleconferences over two successive evenings. If you meet the above criteria and have not received an invitation to join this teleconference and would like to do so, please contact the DSAC office.

Coming up:

1. Dr Colin A. Ross, M.D
17th October – Waipuna Hotel, Mt Wellington, Auckland
19th October – Illot Theatre, Wellington Town Hall, Wellington
21st October – Holiday Inn City Centre, Christchurch

2. Annual General Meeting & Regional Liaison Doctors' Update – 04 – 06 November 2005 - Wellington
Friday, 04 November - AGM – Carol Shand's House, 8 Braithwaite Street, Karori, Wellington
Saturday, 05 November – Regional Liaison Doctors Meeting - To be held at WIPA, Wang House, Level 7, 195-201 Willis Street, Wellington
Sunday, 06 November – Peer Review Meeting - To be held at WIPA, Wang House, Level 7, 195-201 Willis Street, Wellington

3. Initial Paediatric Training – 29th – 31st March 2006 - Auckland
Brochures yet to be finalised.

4. Karlen Lyons-Ruth – March 2006
1st March – Auckland – Waipuna Hotel, Mt Wellington, Auckland
3rd March – Christchurch – Christchurch Hotel, Grand Chancellor, Christchurch
13th March – Wellington – InterContinental Hotel, Wellington

Karlen will be co-hosted by DSAC and the Brainwave Trust.

5. Advanced Paediatric Training – Dates to be Confirmed 2006 - Wellington
Dawn Elder is presently investigating suitable dates for the 2006 Advanced Paediatric Training Course in order to avoid conflict with other conference dates (particularly in Australia) so as to optimise Australian attendance. Dawn is also making enquiries regarding inviting an internationally recognised Adolescent Expert to speak at this course in order to meet expressed interest in having an adolescent update.

6. Lucy Berliner - October 2006
Lucy Berliner has accepted an invitation by Claire Hurst to present a number of workshops in New Zealand in October 2006.

7. Dan Siegel – 2007
Claire Hurst has successfully secured Dan Siegel to present a number of workshops in New Zealand in 2007. Dan will be co-hosted by DSAC and the Brainwave Trust.

Hayley Samuel, DSAC Manager

Report from DSAC Librarian - Janice Giles

Following responses to our questionnaire last year, there has been some refinement to Journal Club content in 2005. Mail-outs now focus more tightly on providing abstracts and summaries of recent papers of potential relevance to members, rather than providing copies of the papers themselves. The intention is to keep members informed and up to date with the minimum of effort and paper.

Every mail-out represents many hours of work by DSAC doctors who give their time to assess literally hundreds of abstracts for potential relevance, review many full-text papers for usefulness, and provide well-informed summaries for members. Copies of reviewed papers are on file at the DSAC office. Janet Say has undertaken to provide reviews, section by section, of existing research on file for current relevance.

These recent changes to the content of Journal Club mail-outs appear to be working well for members.

Janice Giles
DSAC Librarian

Adult Journal Club - Highlights of Review - May 2005

Papers on the differences between stranger and acquaintance sexual assault of adult males and females[1, 2, 3] are available as well as a paper on the sexual abuse of older adults.[4] Finkelhor[5] and his team have done a comprehensive review of the internet initiated sex crimes against minors.

Pornography use was found to be higher in offences against children than in offences against adults, in a study of 561 sexual offenders in Canada.[6]

Monash[7] has reported on the management of adult sexual assault outlining the process of forensic medical examinations and presenting a management flow chart.

There is a study on the hypothalamic pituitary axis analysing the timing of peri-menopause and showing it to be associated with a history of physical or sexual abuse.[8]

The journal club mail out under preparation contains fewer complete papers for general distribution because we have become more aware of copyright issues. We will be highlighting papers that we consider highly relevant for our DSAC Doctors in their medico-legal practice. DSAC Members or Journal Club Members can order these individually directly through the DSAC office in the future (and will incur a cover charge) as we can only review them and are able, in most cases, to only circulate abstracts.

Dr Janet Say, Auckland

1. Stranger and Acquaintance Sexual Assault of Adult Males, Stermack Lana, Del Bove, Giannetta, Addison, Mary
   Journal of Interpersonal Violence, Vol. 19 No. 8, August 2004 901-915
2. Comparison of Sexual Assaults by Strangers Versus Known Assailants in a Community-Based Population, Jones, Jeffrey S et al
   American Journal of Emergency Medicine, Vol. 22 No. 6, October 2004
3. Transactions of the Sixty-Ninth Annual Meeting of the Pacific Coast Obstetrical and Gynecological Society, Wiley, Jennifer, MD, et al
   American Journal of Obstetrics and Gynecology, Vol. 188 No. 6, June 2003
4. Abstract - Sexual Abuse of Older Adults: APS Cases and Outcomes, Teaster, PB, Roberto, KA
   Child Abuse Negl. 2005 Feb, 29(2): 153-67
5. Internet-Initiated Sex Crimes Against Minors: Implications for Prevention Based on Findings from a National Study, Wolak, Janis, Finkelhor, David, Ph.D, et al
   Journal of Adolescent Health 2004; 35:424.e11-424.e20
6. The Use of Pornography During the Commission of Sexual Offenses, Langevin, R, Curnoe, S
   Int J Offender Ther Comp Criminol. 2004 Oct: 48(5):572-86
7. Managing Adult Sexual Assault, Williams A
   Aust Fam Physician. 2004 Oct;33(10):825-8
8. Longitudinal Study of the Inception of Perimenopause in Relation to Lifetime History of Sexual or Physical Violence, Allworth, Jenifer, E, et al
   J Epidemiol Community Health 2004;58:938-943

News from DSAC National Office

Introducing Dee Vorster, PA/Office Administrator

It is with an excited Spirit that I enter the office of DSAC, knowing that my new role might only be a contribution as small as a drop in the ocean, but it is one that comes from within a heart that shares the compassion of helping victims whose lives are so affected by abuse.

My husband, Paul and I came over from South Africa in February 2005, and have absolutely no regrets thus far – touch wood. New Zealand seems to be the country of “Milk and Honey” when comparing vital issues such as unemployment and crime. South Africa is probably the most beautiful country in the world – but things have sadly changed, and we needed to secure a future for our children yet to come.

I have completed my Studies in Public Relations Management in 1998, whereafter I have fulfilled various combined Public Relations and Secretarial roles, mainly in the Medical Sector. Medics have always attracted me in some way or the other, and the combination of seeing abused victims start walking the road of recovery, combined with the medical background, which is what DSAC, is about, was just an absolute perfect fit. One of which I am delighted to be part of.

When we first started off in New Zealand, I took on the role of Medical Receptionist at one of the White Cross Clinics, which was great experience for my career, but I soon found myself not really being a Receptionist, and the role at DSAC came Heaven sent.

My family life has always been my first priority, but apart from adoring my wonderful husband, my second greatest passion in life is music. I have been performing on stage – singing - from the age of 10, and also enjoy song and poem writing, as well as playing the guitar on occasion.

So, this is I, Dee (Deirdré) Vorster, hoping to fulfil every need and requirement, meeting all challenges and visions DSAC has in mind for me!

Project Restore

The Use of Restorative Justice in Sexual Offending

An innovative project is being brought together based on the successful project in the USA by Mary Koss looking at the use of Restorative Justice for cases involving sexual violence. Research to date has shown favourable outcomes and high victim satisfaction rates for participants in Restorative Justice processes.

The collaborative approach of the main players e.g. Auckland Sexual Abuse HELP, SAFE Network, Rape Crisis Auckland and other agencies working with victims and offenders, in the project design and implementation is unique and the driving force for Project Restore. The group is working closely with Restorative Justice providers already providing Restorative Justice in the community to provide a safe process whereby victims can be supported in confronting offenders with the effects of sexual offending and abuse on them and collectively looking for ways to put things right. Often the repercussions of sexual offending reverberate throughout families and communities without any safe way of addressing the impacts and ways to keep other potential victims safe.

Agencies working with offenders can see the benefits in treatment outcomes for their clients given the opportunity of taking responsibility for their actions directly to those involved. It also creates opportunities for the offender to restore their life in a way that will reduce the risk of re-offending, thus reducing the risk of creating further victims.

For victims who are well supported it can be liberating and healing experience to confront the perpetrator, to have their pain acknowledged and be provided with the opportunity to reclaim their sense of personal power.

Victims frequently express feelings of being let down by the court processes currently available to them. Many choose to opt out from reporting offending due to negative experiences. Restorative Justice gives them an opportunity to experience a real sense of justice not often available within the current justice system.

<u>Project Restore - The way forward from here</u>

We are still very much in the early phases of project development, rather than describe how and what we will do, it is more appropriate at this early stage to describe the some of the issues we are working through.

Our first step is to look at the currently available models of Restorative Justice practised in NZ and elsewhere and then decide what needs to be 'different' and 'added to' for sexual violence cases.
Some of the factors of difference to be explored are:

- We anticipate that we will need different protocols and processes for different types of offences e.g. those which have intra-familial aspects and adult survivors of childhood sexual abuse will differ from those of date rape. The known recidivism rates of types of offenders will influence protocols.
- We anticipate we will require a significantly increased amount of pre-conference preparation of participants, the direct victims/ offenders and their whanau especially focusing on emotional safety issues. Who will participate in both pre-conference preparation and conference/ follow up will need to be determined very carefully e.g. therapist of victims will likely to be involved in pre-conference preparation as well as conference support.
- We anticipate that in order to determine the appropriateness of offender participation we will need to explore carefully minimisation and constraints of denial common to sexual offending. A guilty plea won't necessarily be the criteria, especially in cases not going through the criminal justice system.
- We anticipate that the timing of the conference process will be influenced by factors that may not easily fit into the normal criminal system time constraints.
- We expect to not only offer a victim focussed process but also a victim driven and initiated process - how this is managed will need to be explored and protocols developed.

Our initial thinking is that our main referral sources will be:

1. Current clients of SAFE, Auckland Sexual Abuse HELP, Rape Crisis
2. Criminal court pre sentencing via referrals from lawyers, victim advisors, prosecutions, judges
3. Post Sentencing : as part of supervision conditions
4. Post Sentencing : pre release & parole hearings – Te Piriti
5. Community organisations : counsellors, drop-in centres, doctors, hospitals, refugee etc

We expect to focus on offering opportunities for Restorative Justice processes:

- to those otherwise not willing to go through court processes or reporting to police
- as an add-on to already existing services provided by courts/ corrections/community support providers/police

Work on Best Practise Guidelines: this will be ongoing and will likely involve taking each principle and adding specifics on working with sexual violence cases. Rather than 'replace' they will 'add to' with specific guidelines/ criteria and areas of concern to be managed. For example Principle 1: voluntariness, *some already identified issues for sexual violence cases:* coercion by offenders known to victims both on attendance and participation in main body of conference and outcomes. Emotional safety issues for participants and their impact on their participation. How will this need to be managed? What follow up support is needed for victims?

We have a lot of work ahead of us and it is too early to anticipate when we may be able to commence conferencing. Time frames will be dependant on successful fundraising efforts.

For further information on Project Restore NZ Inc. please feel free to contact one of our executive members. Membership forms are available for interested parties.

<u>Contact details for Project Restore</u>

Media spokesperson for Project Restore
Fiona Landon 09 299 6108
fionalandon@wave.co.nz

Auckland Sexual Abuse Help
Kathryn McPhillips, Ph 09 623 1700
k.mcphillips@sexualabusehelp.org.nz

Jennifer Annan, Ph 6231700
j.annan@sexualabusehelp.org.nz

SAFE Network
Nola Forsyth, Ph 09 377 9898
nolaf@safenetwork.co.nz

Researcher
Shirley Julich, AUT
shirley.julich@aut.ac.nz

National Network of Agencies/People Working Against Sexual Violence by Helen Sullivan

At the Stopping Sexual Violence Conference in Taranaki earlier this year a number of groups and individuals met to discuss establishing a national network for people/agencies working against sexual violence. People working in this sector had recognized that the lack of a strong national voice was resulting in sexual violence being left off, or barely acknowledged on the political agenda. In addition, it was felt that a national network would enable groups to share information, resources and undertake collaborative projects such as training.

At this meeting a Steering Group was established and charged with the task of pulling together a possible structure for such a network. The meeting was clear that the interest was in a network or association rather than a national body.

After successfully accessing some end of year funding through Child Youth and Family, the Steering Group met in Wellington in June to begin the first steps in this process. There was representation from a number of groups including the National Collective of Rape Crisis, offender treatment services and survivor agencies. The Steering Group identified it purpose and aims and a timeline for action.

Purpose of Steering Group:

- Establishing a national organisation to represent the interests and needs of agencies and individuals working in (providing services, preventing or researching) the field of sexual violence.

Aims and Timeline of the Steering Group:

- Identify possible interested parties and circulate information about network – mid July 2005
- Ensure appropriate representation on the Steering Group, in particular Maori, South Island and male survivor groups – November 2005
- Seek additional funding to enable the Steering Group achieve its objectives
- Develop and circulate a draft mission statement, constitution and structure - December 2005
- Hold open hui for all interested parties in April 2006
- National organisation legally established by end of June 2006

Where are we now?

The Steering Group is intending to meet in November. An initial email list for agencies working in the sexual violence sector has been developed and the minutes from the meeting in Taranaki and the Steering Group's first meeting have been circulated. Representation of the sector groups identified above is being followed up. The Steering Group is also looking at possible structures, constitutions and networking with other related national bodies.

The Wellington Sexual Abuse HELP Foundation has taken the responsibility to be the lead agency for funding purposes at this stage and to coordinate the activities of the Steering Group. The contact person is Helen Sullivan (wgtnhelp@paradise.net.nz, or phone: 04 499 7530; fax: 04 499 7533)

We would be keen to hear from people on two counts

1. If you are interested in being informed about the development of the network and participating in that process. Please send your name and contacts details to Helen Sullivan.
2. If you have a good idea for a possible name, please send us your ideas.

Helen Sullivan

The Paediatric/CYFS Liaison Group Report

Carol Shand as DSAC President and Jenny Corban are now members of the Paediatric Society Child Protection Special Interest Group which is chaired by Patrick Kelly. Its 39 members include paediatricians working in child protection, DHB Family Violence Intervention Coordinators and Child Protection Coordinators. The SIG met in Wellington on Saturday 7th May 2005 and there will be telephone conferences as necessary. There is a list server for discussion and information.

There has been very welcome progress with respect to paediatrician training in child sexual abuse. Patrick Kelly and Russell Wills have been recommending to the Royal Australasian College of Paediatrics on behalf of their respective special interest groups (Child Protection and Community Child Health), that sexual abuse training be mandatory for advanced paediatric trainees. The New Zealand General Paediatric Specialist Advisory Committee has responded positively and New Zealand trainees will now have to attend either specific short course training in child sexual abuse (such as the DSAC training course), or have a minimum of three months appropriately supervised practice in child protection with a significant component of child sexual abuse. It is also likely that this will be introduced in Australia but probably not until 2007.

There is a noticeable variation in the pattern of service delivery for paediatric sexual abuse assessments. The Paediatric Society Child Protection Special Interest Group plans to form a Working Party of paediatricians to work with DSAC to develop a comprehensive survey of all DHBs on this question to clarify how services are delivered and by whom. The goal would be equitable access throughout the country with paediatric departments supporting the work, either via the paediatricians or DSAC trained GPs.

Dr Jenny Corban
Paediatrician, Hastings

ACC Therapy Guidelines

After enormous effort on Dr Kim McGregor's part, the ACC Guidelines for Therapists Working with Adult Survivors of Child Sexual Abuse are now available on the web. They can be downloaded from:

http://www.acc.co.nz/wcm001/groups/external_providers/documents/internet/wcm2_020341.pdf

These guidelines are currently being re-written by a Massey University Team with an expected completion date of 2006.

FAMSAC Sexual Assault Symposium - Canberra 26-27th November 2005

The Registration Programme and Preliminary Brochure for this conference is now available. The theme is "Best Practice: What to do and Why?"

If you would like a copy of this brochure emailed through to you then please contact the DSAC Office.

ESR Liaison Group Report

1. Updating Medical Examination Kit (MEK) & Assault Medical Protocol (AMP)

Meetings between Police, Environmental Science & Research Ltd (ESR) & DSAC representatives resumed in August. Review of sampling techniques and sampling sites continues with recent advances in DNA identification methods making it necessary to revise previous directions. Although it is frustrating for the entire group when we have to revise things, it is important to include "latest" advice in the final product.

2. Feedback forms from ESR to doctor

ESR staff are assessing draft feedback forms at present. The concept of feedback being appropriate has been accepted, which is good news.

3. International Forensic Science Symposium (IAFS) 2005

This recent forensic science conference in Hong Kong was a good opportunity to liaise with forensic specialists from around the world and get an international opinion about various issues. There were a couple of interesting presentations covering techniques for maximizing sample collection when doing fingernail swabs and also looking at wet and dry DNA swabs both of which may have useful implications for us in New Zealand.

Clare Healy, Christchurch

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

Education Sub-Committee Report

1. 2006 Advanced Paediatric Meeting
Plans for this biennial meeting are underway. We hope to invite an overseas expert in the area of adolescent issues relevant to DSAC members and thus attract people who are examining the adult/adolescent age group as well as the child/ adolescent patients.

2. There was discussion around the idea of some kind of feedback for doctors who appear in court. ESR routinely get feedback on their court appearances either from peers, who happen to be present, or from counsel. This idea is to be investigated further by Clare Healy and presented at a later date.

3. Some doctors have difficulty getting to peer review meetings either because of relative geographical isolation from appropriate peers or because of time commitments. It has been proposed that a pilot telephone peer review meeting be held in October. Penny Kagan is organizing it, as she has experience of a similar project used for rural GP peer review. Further information may be obtained from the DSAC office for any interested participants.

4. Sexual Assault Conference, Canberra – November 2005
This is a stand-alone conference to be held in November, rather than the usual conference which is piggy-backed onto the Australasian Sexual Health Conference.

5. Suggestions of news/ useful clinical points/ articles of particular interest which will be circulated a couple of times a year to the DSAC Regional Liaison Doctors was discussed and a mail-out will hopefully be initiated before November 2005.

6. A successful Adult Basic Training Weekend was held in Wellington in July 2005. Thanks were given to organizers and speakers.

Clare Healy, Christchurch

Accreditation Sub-Commitee Report

Three meetings of the sub-committee have been held this year so far in February, July and August. The next meeting is planned for 18th October.

Some of the major issues facing us are:

1) Improving the uptake of accreditation and reducing the barriers to entering the process. Ultimately safe consistent practice and the perception of our professional credibility by others will rely on it so it needs to be achievable. A common barrier identified so far is the difficulty some candidates have in finding an on-site supervisor.

2) Completion of the new application forms is being urgently sought to clarify the procedure and requirements.

3) Some candidates see few patients and often have none to present with abnormal or even non-specific findings and hence are unable to show evidence of their ability to interpret these findings.

Improvements we are hoping will assist candidates:

1) A report will be sent to individuals whose accreditation is due to expire in the next 3 months as a reminder.

2) Accreditation status reports will be sent to Regional Co-ordinators at least once a year relating to all the doctors in their area. It is hoped that they can encourage their local doctors to remain current and provide peer support. It could be something that might be worked on at a peer review session and co-operation with supervisors reports arranged.

3) Candidates are encouraged to communicate with the DSAC office and committee about their individual circumstances and difficulties (such as the supervision issue) so these can be addressed on a case-by-case basis.

4) Training sessions are being attended by committee members to speak about accreditation and be available to answer queries.

5) Consideration is being given to develop and use mock cases where real cases with findings are not available. This would be used as a last resort and in a cautionary manner in addition to the candidate's own cases.

Jane Batchelor, Chair

DSAC Submission: Provision of health services for adult victims of sexual assault/abuse

01 August 2005

INTRODUCTION

1.1 **Doctors for Sexual Abuse Care (DSAC)** is a national organisation of doctors who provide medical care for victims of sexual assault. DSAC itself is not a service provider and has no funding to do so, but DSAC trains, supports and provides accreditation to doctors who do provide services. The doctors providing the services are predominantly general practitioners, sexual health physicians and paediatricians. DSAC has an office based in Auckland and Regional Liaison representatives in most districts.

1.2 This submission is directed specifically to the provision of care for adults and older adolescents (where this care is not provided by paediatric services).

1.3 DSAC has made submissions previously1 to health funding authorities which covered paediatric as well as adult management. Paediatric care needs to be developed in association with the general paediatric services and is not addressed in this submission.

1.4 DSAC believes that there should be a national interagency policy developed between the Ministry of Health, District Health Boards, Police, Accident Compensation Corporation and Doctors for Sexual Abuse Care on funding and provision of medical care for victims of sexual assault.

FUNDERS

2. Ministry of Health and District Health Boards

2.1 There is no clear national policy of provision of health care but there are some recognised arrangements.

2.2 District Health Boards are funded to provide emergency care in the first seven days after an accident through the Public Health Acute Levy.

2.3 Sexual Assault medical services are provided for under the **MOH Service Specification Sexual Health July 2001**

This contract lists the components of care to be provided as part of the sexual health services by District Health Boards.

" (Tier 2 Service Specification for Sexual Health,
5. Service components – Processes: sexual abuse and assault services)
Services specified are:
On referral from Emergency Services or Police, provide counselling and medical care in consultation with the local Doctors for Sexual Abuse Care[2]

- *Provide medical care as required*
- *Collect forensic evidence*
- *Diagnostic testing*
- *Counselling"*

3. Accident Compensation Corporation

3.1 ACC accepts the health consequences of sexual assault as injury by accident.

3.2 ACC has developed a contract for provision of medical care with individual trained providers.

3.3 In some places ACC has contracts in place with DHBs for provision of sexual assault care to adults but the development of these has been dependent on local initiatives where managers and doctors have been able to organise it.

3.4 These DHB contracts do not cover acute care in the first seven days after injury. Funding for this is provided by ACC as part of the Public Health Acute Levy.

4. Police

4.1 The NZ Police have a policy for management of complaints of adult sexual assault which details appropriate police management and interaction with medical services.

4.2 The Police pay doctors, and nurses in some areas, for providing acute medical assessment for the purposes of collection of forensic information and accept that this also covers the cost of non-forensic medical components of that care.

4.3 In some districts there are local arrangements in place for police payment for nursing care, contribution towards development or provision of premises, contribution to cost of security services, contribution to continuing medical education where it relates to forensic matters etc.

PROVISION OF SERVICES

5. Importance of good quality appropriate medical care

5.1 Victims of sexual assault/abuse suffer injury which results in both short and long-term serious health problems. These may be physical injuries, unwanted pregnancy, acquisition of sexually transmitted disease, mental trauma and, sometimes severe, psychiatric illness.

5.2 Treatment services are essential for male and female victims of all ages because past sexual abuse is clearly associated with the development of long-term ill health. Treatment is aimed at rehabilitation to as near-normal a life as possible.

5.3 Adequate provision of medical and therapeutic services for victims of sexual assault is cost-effective. Local experience and international literature demonstrate that appropriate care diminishes long-term ill health and social problems such as the development of high-risk activities - intravenous drug abuse, alcohol abuse, high risk sexual behaviours leading to acquisition of STIs and increasing risks of HIV/AIDS.

5.4 Perpetrators of abuse seldom offend only once, and if not treated are likely to leave many victims throughout their lifetime. Treatment of this group should be considered as an important preventive health measure. The last few years have given rise to a greater understanding of the significance of adolescent offenders and their need for effective therapeutic intervention.

6. Current service provision in New Zealand

6.1 The development of services for sexual assault victims has depended on local initiatives and is still inadequately funded. Organisers of health services have often ignored their responsibility to provide effective health care for this group of patients and have left large gaps in treatment services. There has been no co-ordinated approach over the country or within regions. In many areas services are still inadequate and ad hoc.

6.2 Good models have been developed in places like:

- Auckland with a paediatric and adolescent (<20th birthday) service situated in a multi-agency centre and an adult service within the sexual health service. **The adult service is now at risk with the abrupt withdrawal of support by the MOH Contracted Provider the Auckland Sexual Health Service.**
- Wellington has a service delivered through the WIPA Sexual Health Service.
- Christchurch has a service run by a charitable trust with which all DSAC trained forensic medical examiners hold a contract (this Trust has some funding from the DHB. The rest comes from Police payment for forensic services & ACC Contract for children's services.)
- A variety of other centres have developed services with different arrangements but all the services suffer from inadequate support and depend largely on the goodwill of overstretched doctors.

6.3 Some well-established services are at risk of collapsing because of withdrawal of District Health Board support (Auckland). In other areas such services are still inadequate and ad hoc and there is no health or ACC funding, only Police contribution as part of forensic examinations.

6.4 In areas where the survival of services has depended on the goodwill and donation of time and resources by local doctors, unsupported doctors have been obliged to withdraw their services; for example Rotorua.

6.5 Withdrawal of services in these areas can be easily threatened as has happened in Auckland as there is no firm agreed policy which is adhered to about the responsibility of the different agencies.

6.6 There is an urgent need for a planned approach, on a national basis, for delivery of medical services for sexual assault. It is important to ensure that there are no districts which miss out entirely, or areas where services remain very inadequate.

6.7 The MOH Service Specifications (see 2. above) offered an opportunity to reconsider services and to ensure adequate provision of care. However the provision of sexual assault services as part of Health's responsibility is still variable in quality and availability around New Zealand.

DEVELOPING SEXUAL ASSAULT SERVICES FOR NEW ZEALAND

7. Essential Components of a Quality Sexual Assault Health Service

7.1 Sexual assault health services should include prevention, acute treatment for victims with follow-up, long-term treatment and rehabilitation for victims and their families.

7.2 Sexual assault health services should be accepted as core health services and purchased by Ministry of Health as a shared arrangement between the three funders (MOH, ACC and Police).

7.3 Sexual assault health services should, in principle, be at no cost to the patient who is a victim of a crime. The occasional exceptions to this may be for treatment of offenders, where a partial charge may encourage a commitment to the treatment.

7.4 All services should be culturally sensitive in accordance with the spirit of the Treaty of Waitangi.

7.5 Easy access to health services for all victims of sexual abuse is essential. This requires 24-hour availability of emergency services and easy access without waiting lists for longer-term treatment facilities.

7.6 These services need to be provided by highly trained staff in an environment that is quiet, private and properly equipped for the purpose.

7.7 Because of the nature of the original assault/abuse, the gender of health personnel will always need to be considered.

7.8 Standards of care should meet accepted national and international standards.

7.9 Because of the significant medico-legal implications and the rapid advance in knowledge in the field, peer review and clinical audit is essential and requires that doctors and other health personnel work in a multi-disciplinary team and in close association with peers.

7.10 All services must have a built-in component for data collection and outcome research.

7.11 As an essential part of the service, adequate funding should be available for education, the setting and maintaining of standards, peer review and audit as well as data collection and research. This should not just be left to the discretion of individual practitioners but built in to the arrangements for provision of services.

7.12 Policies for prevention of sexual abuse by medical personnel should be developed in every institution and service, with clearly established procedures for handling complaints.

7.13 Treatment should also be available to offenders, whose treatment is preventive and protective of the wider community's interest.

8 Development of an Integrated Service

8.1 The essential components of such health services should be provided by the District Health Boards as an integrated part of their responsibility for the health of victims of all ages, both male and female.

8.2 Sexual assault services can be appropriately delivered as part of a sexual health service which is now happening in some areas and purchased by the District Health Boards in accordance with the MOH service specifications for sexual health.

8.3 Sexual assault services need to be planned for 24-hour 7-day a week availability. Where the numbers of such patients are small, creative planning is required to find an appropriate venue. This may mean using sexual health services and/or other facilities (Outpatients, GP's surgeries) as appropriate for that geographical area. Whatever arrangement is made it needs funding from DHBs to support the planning and infrastructure and trained personnel including administration.

8.4 It may not always be necessary to have sexual assault services within a hospital building as long as a close association with the 'base hospital' is developed to provide access to emergency, in-patient and specialised STD facilities. A community-based service should never be planned in isolation from these specialist facilities.

8.5 Close liaison should be developed with accident and emergency services, with clear protocols to ensure lines of clinical responsibility are well defined between hospital staff and forensic medical examiners when patients are seen in an emergency department.

8.6 Accident and Emergency Departments should, where possible, be avoided for provision of sexual assault medical services unless there is concomitant serious physical injury. A busy emergency department is not conducive to providing an appropriate supportive and therapeutic environment for victims of a recent sexual assault. Where there is no alternative to this, planning is essential with allocation of the necessary space, training, staff and resources to provide for the special needs of recently traumatised sexual assault victims.

8.7 The complex nature of such health care for adults requires close co-operation with other essential health services such as gynaecology, sexual health, laboratory and mental health services.

8.8 Nursing and administrative support for medical examinations and follow-up is important to improve the quality of care provided, as with any other area of medical care.

8.9 DSAC's policy on minimum criteria for premises and equipment required for medical management of sexual assault is published in the DSAC manual.3

9. Interface with other agencies

9.1 A 24-hour emergency service providing health services for victims of sexual assault must be developed in co-operation with the Police who have the legal responsibility for investigation and prosecution for sexual offences.

9.2 Medical services should be provided in close co-operation with support and counselling agencies such as Victim Support, Rape Crisis and the Help Foundation to provide a 24-hour counselling support service to ensure victims obtain good crisis counselling and a beginning to their healing process from the first medical contact.

9.3 The legal responsibilities of health personnel must also be considered. Every DHB must be able to identify personnel within their organisation who are knowledgeable about these legal responsibilities to be a resource for other staff.

9.4 As with other accidental injury the Accident Compensation Corporation (ACC) has a responsibility for the cost of treatment and rehabilitation of victims of sexual assaults. However availability of health services should reflect medical and health needs and not be restricted by any requirement of proof of an assault.

9.5 Other models can work but they must meet a nationally agreed standard of care. Funding for these services can be shared by Health with the Police and the Accident Compensation Corporation but there must be a national strategy to see that services exist in all areas.

9.6 There are best practice well functioning models of sexual assault medical care in other similar countries which could be looked at such as some new models developed in the UK and in Canberra, Australia.

10. Therapeutic services

Long-term and historical abuse is currently almost entirely neglected by the health services. Such an important part of a mental health service should not just be left to voluntary agencies like the Help Foundations and Rape Crisis centres (which have precarious funding) and independent counsellors who are partially subsidised by ACC. These agencies and therapists play an integral part in the care of sexual assault victims but they need to be backed up by mental health services to provide treatment for the more seriously ill patients and for those who cannot afford or who do not fulfil the criteria for ACC funded therapy.

Dr Carol Shand, MBChB, FRNZCGP, FAChSHM
DSAC President

[1] DSAC Submission to MOH and all District Health Boards on Health Services for Victims of Sexual Abuse, 2001

DSAC Submission to the Transitional Health Authority re: Provision of Health Services for Victims of Sexual Assault/Abuse, 1997

DSAC Submission to MOH and all District Health Boards on Health Services for Victims of Sexual Abuse, 1995

DSAC Submission to Crown Health Enterprise Advisory Committees in establishing the viability of a service, 1992

DSAC Submission to Area Health Boards on the Provision of Sexual Abuse Services, 1990

[2] DSAC is not a service provider. These doctors are DSAC trained and the name has been loosely used in this document to describe the rosters of doctors who do the work.

[3] The Medical Management of Sexual Abuse Fifth Edition, 2002 Section 9.2

Conference Report - IAFS, Hong Kong - August 2005

The International Association of Forensic Sciences [IAFS] held their triennial conference in Hong Kong this year. A bit of background information lifted straight from their website may inform you further:

" Inaugurated in 1957, IAFS is the only worldwide Association to bring together academics and practicing professionals of various disciplines in forensic science. They include:

- forensic scientists, who are generally responsible for autopsies and for clinical forensic medicine i.e., examination of victims of rape and other types of violence in adults and juveniles, taking sexual and other delinquents into care, etc.
- those working in police, government or private forensic laboratories, dealing with fingerprints, biochemical grouping, drug analysis, toxicology, ballistics, trace evidence examination, accident reconstruction, etc. and
- those working in other branches of forensic science, such as forensic psychiatry, physical anthropology, medical law and bioethics, forensic odontology, etc.

The aims and objectives of IAFS are:

- to develop the forensic sciences;
- to assist forensic scientists and others to exchange scientific and technical information, and
- to organize meetings

According to its Constitution, the International Association of Forensic Sciences organizes a World Meeting every three years. Since 1957, a total of 16 Triennial Meetings have been organized in major cities around the world."

Last year, I was invited to be on the scientific committee responsible for the clinical forensic medicine stream at the conference. Having not ever heard of IAFS at that point, I was a little bemused but after finding out a little more I agreed. The conference took place in the amazing Hong Kong Convention and Exhibition Centre. This building comfortably hosted both our conference of 1,200 delegates and a computer seminar with over 6,000 visitors at the same time!

The conference took place over five days with the first day being devoted to plenary sessions for all delegates. The remaining four days covered topics as diverse as "Forensic odontology" and "Questioned documents"- I never quite got to the bottom of the latter topic. The streams that interested me particularly were those covering general clinical forensic medical issues and sexual assault. Many of the participants were leading experts in their own countries and it was fascinating to hear how different countries dealt with similar issues in diverse ways. Other topics I found interesting were those concerning law and ethics and wrongful convictions. I was impressed with the spirit of cooperation between different specialties and the efforts that the delegates made to try and promote best practice in all areas, particularly supporting the theme of the conference, which was "Justice Through Science".

One whole day was taken up with the topic of sexual assault examination. This was the day when I presented my short paper .The subject of my paper concerned the value of DNA analysis of penile swabs taken from alleged assailants following sexual assault. I am grateful to two staff from ESR who helped me access relevant information. The pilot study suggests that these swabs may be very valuable particularly if taken within twelve hours of alleged assault and if the assault involved penile-oral contact. Later on in the day I took part in an interactive panel discussion covering several practical and ethical dilemmas which may occur whilst practising sexual assault examinations. It was particularly useful to discuss with those from other countries, issues such as the best way to take fingernail samples and whether or not to lubricate implements, prior to use. I left Hong Kong having made many new friends and contacts who may well provide helpful advice for our services in New Zealand, in the future.

Clare Healy, Christchurch

DSAC Forensic Training, Wellington - 29 - 31 July 2005

Dr Jane MacDonald, DSAC Vice President

Dr Juliet Broadmore, DSAC Executive Advisor

DSAC Accreditation for Paediatricians – Dr Russell Wills

Accreditation is a worthwhile activity for paediatricians undertaking sexual abuse work and should be strongly considered. It qualifies for the quality assurance part of MOPs with 3 points per hour (so keep a record of the number of hours spent completing your application), as it is a review of the person's practice. It is a valuable opportunity for peer review of your practice and means you are accredited by Police and ACC for payment.

The requirements for Provisional DSAC Accreditation are as follows:

1. You need to be working in appropriate medical practice (eg GP, Family Planning, O&G, Paediatrics)
2. Nominate a principal DSAC Supervisor
3. Belong to a peer review group
4. Have received suitable preliminary training (such as a DSAC training weekend)
5. Read the DSAC Manual
6. Fill in the YELLOW accreditation forms and submit them to the DSAC office along with the required references

The DSAC Accreditation Committee reviews this application and when you are granted this Provisional Accreditation it will last for one year. Your name will be sent to the Police and ACC so that you can sign up for Police work and/or the ACC contract, in order to be paid for any non-police work during that year. This gives you the year to get cases together to apply for full accreditation.

The requirements for full DSAC Accreditation are as follows:

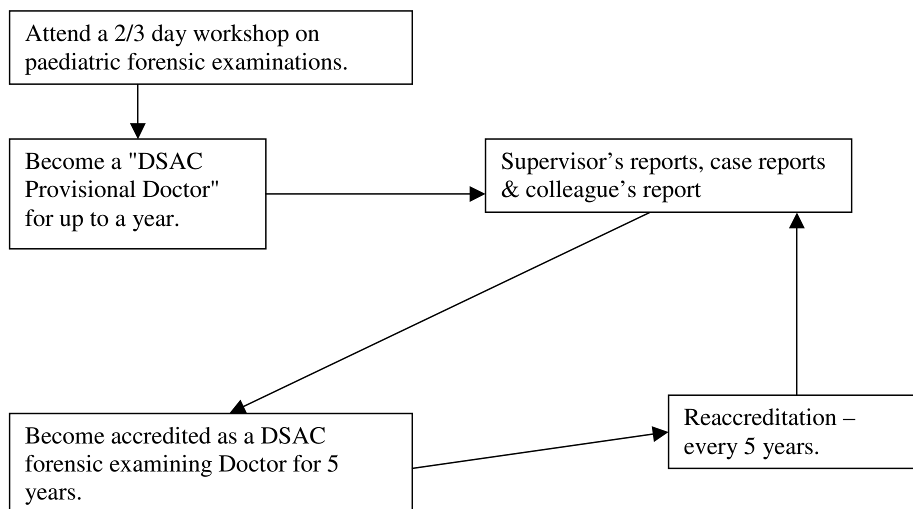
1. You need to have completed at least two fully supervised examinations
2. Completed at least two partially supervised examinations
3. Submit to the DSAC office:
    - Supervisor's report on each of these examinations
    - Principal supervisors report
    - Completed application form
    - Full documentation of two cases
    - Include a deposition statement from each case.

This application is considered by the Accreditation Committee, and then endorsed by the Executive. Successful applicants will then have their name forwarded to Police and ACC as being fully accredited. Full Accreditation is for 5 years. After this time re-accreditation needs to be applied for.

If you are practising in sexual abuse work on your own or are concerned that these requirements might be difficult to achieve for any other reason please talk to an accreditation committee member, phone numbers available from the DSAC Office.

Dr Russell Wills, Community Paediatrician, Napier & DSAC Accreditation Sub-Committee Member

DSAC ACCREDITATION FLOW CHART



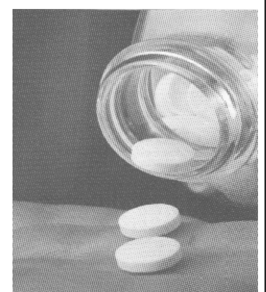
Azithromycin

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.co.nz, or fax: 09-376 0790



DSAC Diary of Events 2005/2006

DSAC is a RNZCGP CME Registered Special Interest Group

For all events Apply to: DSAC National Office PO Box 90 723, AUCKLAND, 5/4 Warnock Street, Grey Lynn, AUCKLAND
Tel: (09) 376 1422 Fax: (09) 376 0790 email: dsac@ihug.co.nz website: www.dsac.org.nz

Dr Colin A Ross, M.D.

Three One Day Seminars

Treatment of Complex Dissociative Disorders

Auckland - Monday, 17th October 2005
Waipuna Hotel, 58 Waipuna Road, Mt Wellington

Wellington - Wednesday, 19th October 2005
Illot Theatre, Wellington Town Hall,
111 Wakefield Street, Wellington

Christchurch - Friday, 21st October 2005
Holiday Inn City Centre, Cnr Cashel & High Streets

Colin Ross will also be giving the keynote address at the 3rd Annual MAKING SENSE OF PSYCHOSIS Conference in Auckland, 18 &19 October, hosted by the International Society for the Psychological Treatment of Schizophrenia (ISPS). For further information contact Melissa at m.taitimu@auckland.ac.nz
People registering for both the DSAC Seminar and the ISPS Conference will receive a 10% discount on both.

DSAC Peer Review Teleconference

Wednesday, 19th October 2005 at 8pm

A trial Peer Review Teleconference for doctors who are current DSAC Members working in isolation around the country, and who have difficulty arranging peer review, is being held on Wednesday, 19th October 2005 (DSAC will be meeting the cost). If you meet the above criteria and have not received an invitation to join this teleconference and would like to do so, please contact the DSAC office.

Professor Karlen Lyons-Ruth, Ph.D.

Associate Professor of Psychiatry, Harvard Medical School, USA

Three One Day Seminars

Auckland: Wednesday, 1st March 2006
Waipuna Hotel, 58 Waipuna Road, Mt Wellington

Christchurch: Friday, 3rd March 2006
Christchurch Hotel, Grand Chancellor, 161 Cashel St

Wellington: Monday, 13th March 2006
InterContinental Hotel, Cnr Grey & Featherstone Sts

DSAC AGM

VENUE
Carol Shand's House
8 Braithwaite Street, Karori, Wellington
DATE
7.00 pm - Friday, 04 November 2005

DSAC Regional Liaison Doctors' Meeting & Peer Review

VENUE: WIPA, Level 7, 201 Willis Street, Wellington
DATES: Saturday, 05 November 2005 - RLD Meeting
Sunday, 06 November 2005 - Peer Review

This meeting is for current Clinical Practitioners - please contact the DSAC office for more information

DSAC Basic Paediatric Training

Medical Assessment of Sexually Abused Children & Adolescents

VENUE: Marion Davis Library, Auckland Hospital, Park Road, Grafton, Auckland
and
Puawaitahi, 99 Grafton Road, Grafton, Auckland

Dates: 29 - 31 March 2006

DSAC Advanced Paediatric Training Course and 3rd Combined Australia and New Zealand Meeting on the Medical Assessment of Sexually Abused Children and Adolescents

VENUE: Wellington - to be confirmed
DATES: 2006 - to be confirmed

LETTERS TO THE EDITORS

Letters to the Editors can be submitted, although publication, editing and abbreviation are at the Editors' discretion. While the principle of 'right of reply' to articles and letters published in the Newsletter is accepted, this right is not automatically granted and is subject to Editorial discretion and the limitations of space - DSAC news and information have priority. All letters submitted must include appropriate contact details and email submissions are preferred so as to reduce the possibility of error in transcription.

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