DOCTORS FOR SEXUAL ABUSE CARE

PO BOX 90723, VICTORIA STREET WEST, AUCKLAND 1142
PHONE: (09) 376 1422 FAX: (09) 376 0790 email: dsac@ihug.co.nz website: www.dsac.org.nz

NATIONAL NEWSLETTER

EDITORS: SANDRA RHIND & CAROLINE CORKILL ISSUE No. 75 JULY 2008

Message from the Executive Chairperson - Dr Marie Burke

Hello again – and sorry for my absence from the last newsletter. I got the dreaded phone call from the UK regarding parental illness and had to drop everything and go. I am back now though (obviously). It makes me realise there has been a recurring pattern to my thoughts recently; we don't know what we don't know – and nor do a lot of other people.

Dr Marie Burke
DSAC Executive Chairperson

Let me explain. I didn't know until I got the phone call from the UK that I had bizarrely convinced myself that my parents and everyone else I love are going to live forever – or at least until sometime so far in the future I don't have to think about it. I also didn't know when it started how complex and frustrating SAATS was going to be – and neither did anyone else, which makes me feel a bit better. I also didn't know how little some people in ACC, MOH and the Police understand about what DSAC is and the difference between what DSAC does nationally and what the doctors and nurses providing the services locally actually do – and the fact that they do a lot of it in their own unpaid time e.g. liaising with local police etc. This brings me to the importance of local level agreements as part of the SAATS process and what is paid for by this new contract. We have to think about these things before we need them e.g. payment to cover peer review, depositions at a reasonable rate (some of which take a long time to write and rewrite after proper peer review), nurse time (in Christchurch we routinely have a nurse present at all examinations and it is VERY worthwhile). Be aware these are examples, NOT a comprehensive list. Please keep in close contact with the DSAC office during negotiations.

Another thing to have become apparent that people don't know, is that DSAC is not a service provider – I have been amused and occasionally stunned when people seem to think we are some sort of government department rather than a voluntary organisation working out of a "less than salubrious" office which is smaller than my veggie patch. My veggie patch is not large. Thanks however to the Executive and especially Hayley's untiring work, people now know more than they used to (or don't know less than they used to but that's just complicating matters).

SAATS meetings are continuing. Some changes have been made to ACC staff but we are hoping for good institutional memory. Hayley and I also met with Hon. Steve Chadwick in her capacity as Associate Health Minister (she is Women's Minister and DOC Minister as well) recently.

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She was very generous with her time, and very complimentary towards what DSAC has achieved on the smell of an oily rag. (I suspect oily rags are going to become more expensive as oil prices continue to soar though.) She is keen to table an agenda item for the Sexual Violence Task Force and initiate discussion with other government agencies on how to support the DSAC national office at this time – especially with the rise in work that is expected as SAATS rolls out.

We also delivered a presentation to the Police Executive Committee in May to emphasise the importance of local level agreements with regard to SAATS. Watch this space.

The next RLD meeting is going to be 7-9th November. RLDs (especially new ones) please put this in your diary now as I am keen for as many RLDs to attend as possible. It is a supportive and useful way to keep everyone informed and provide some networking and peer support. Peer review this year will have a different format – a letter will be sent out nearer the time explaining how. We are planning lots of education updates on the Saturday that will have direct relevance to the work we are all doing.

Peer review and accreditation remain very important and will become even more so given that SAATS requires accreditation to be up to date. If you are doing very few cases and feel uncertain how to approach accreditation please contact the Accreditation Committee via the DSAC office to ask for advice – don't just ignore it and hope it will go away! It is my experience that once you get started it can be very straightforward. Remember accreditation is about providing a good service – to the victims we examine, the police during their investigations, and to the justice system when we write depositions and go to court – we should be aiming for the best standards. It is a supportive not adversarial process.

Talking of court – I experienced a case recently where the defence implied to the victim when she was on the stand that the tick boxes we record in the MEK implied consent! I know – another thing I didn't know could happen! I am now routinely discussing this with the Crown Prosecutor as part of my usual "before court process" in case it comes up again. I strongly encourage everyone to meet, or at least have a phone conversation, with the Crown BEFORE you get to court – it could save a lot of stress.

I thought I would finish on things that I do know. DSAC remains the most supportive environment I have ever worked in. I am always struck by the enthusiasm of Hayley and Meagan in the office (despite its veggie patch size). We should be proud of 20 years of aiming for and maintaining standards in the area of sexual assault forensic medicine.

Bye for now – off to see if there are more things I don't know!

Dr Marie Burke
DSAC Executive Chairperson

Manager's Report - Hayley Samuel

April and May were most successful training months for DSAC with both the Initial Paediatric Training Course and the Adult Medical/Forensic Training Course registrations reaching maximum capacity (40 and 41 attendees respectively)! Both courses were very highly rated and received excellent feedback. Examples from the Adult Course follow:

- "Very well organised – small details thought of" - PMO
- "This was an incredibly informative and helpful course" – Doctor
- "This was an excellent seminar and I didn't feel like I was giving up my weekend. Instead was gaining incredible insight into DSAC world" – Doctor
- "Very well organised, fantastic resources, very comprehensive" – Nurse
- "A fantastic course, well done. I now feel well prepared to start the work" – FPA Doctor
- "I feel much more confident about proceeding with this work now" – GP
- "A wealth of knowledge. Great advocacy for sexual assault complainants in New Zealand. What would we do without your input?" – Nurse
- "Brilliant!" – Nurse
- "One of the best courses I've attended, well organised with very relevant content"

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Dr Patrick Kelly
Initial Paediatric Training Course 1-4 April 2008

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We were most grateful to the NZ Police for funding the Adult Training Course which meant that attendees were not required to pay a registration fee. Police Districts also supported attendance at the course by clinicians in their regions by providing financial assistance for travel and accommodation required to attend. Thank you NZ Police!

On behalf of the DSAC Executive I would like to extend our thanks and congratulations to Drs Patrick Kelly, Silvana Campanella and the team at Te Puaruruhau for all of their work involved in running another fantastic Initial Paediatric Training Course. Also to Drs Christine Foley, Min Lo and Christine Foley for delivering the sterling Adult Medical/Forensic Training Course (which had record attendance since 1992).

Meanwhile the DSAC Executive have been busy seeking government funding for DSAC the organisation. The advent and implementation of the Sexual Abuse Assessment and Treatment Service has, and will continue, to create a financial burden on the organisation as the demand for advice and support from DSAC has increased significantly. It is imperative that DSAC continues to be involved in the development and implementation of this service, yet the organisation is unable to shoulder the costs associated with doing so in our current unfunded capacity. We are hopeful that a funding solution will be found and soon…

To end this report I convey a message of thanks, on behalf of the Police Executive Committee, to all of the DSAC Members and trained clinicians who have worked, or continue to work, in this speciality field of medicine. Marie Burke and I met with the Police Executive on the 21st May and their respect for you all, and the work of DSAC the organisation, was most evident.

Hayley Samuel
DSAC National Manager

Initial Paediatric Training Course 1-4 April 2008

Reality Court Session
Adult Medical/Forensic Training Course 16-18 May 2008

Reality Court Session
Initial Paediatric Training Course 1-4 April 2008

Chrissie Sygrove, Nurse Specialist, Pohutukawa Clinic
presenting "The Nursing Role Session"
Adult Medical/Forensic Training Course 16-18 May 2008

Congratulations to Dr Carol Shand

Dr Shand has dedicated her professional life to enhancing women's health. For 43 years (to date) she has been a respected and much loved Wellington General Practitioner. She delivered thousands of babies between 1964 and 1996; and was one of very few doctors in the 1960s who would provide oral contraceptives to unmarried women. She has always advocated for, and facilitated the provision of access to safe abortions for New Zealand women.

In 1985 she was a founding trustee of the Wellington Sexual Abuse Foundation. This was the beginning of her commitment to working for and with victims of sexual assault and child sexual abuse. It has included being part of the voluntary roster of doctors who can be called out in the middle of the night by the Police to conduct forensic medical examinations in cases involving alleged assault.

Dr Shand was one of the founding members of Doctors for Sexual Abuse Care (DSAC) in 1988. This is a professional, voluntary, non-profit organisation of doctors and nurses who provide training for doctors and nurses, set quality standards for the medical evaluation of sexual assault and child sexual abuse and provide peer review and support for doctors, as well as advocacy for victims. In this capacity alone it would be fair to say that Dr Shand has often spent 15 hours per week in voluntary work for the last 19 years. She was the driving force behind most editions of the "DSAC Medical Management of Sexual Abuse" which is an internationally recognised resource.

Dr Shand's approach in this challenging area of medical practice is characterized by her professionalism and avoidance of "leaping to any conclusions" combined with compassion for the patient and all those affected by any alleged assault.

She has juggled the responsibilities of her employed roles and her many voluntary roles with being a mother of three (now adult) children and grandmother of two children.

It is not possible in these paragraphs to acknowledge all of the extraordinary contributions Dr Shand has made in devoting her professional life to ensuring the health and well-being of New Zealand women, men and children is maximised.

The honour of becoming a Companion of the New Zealand Order of Merit is a fitting recognition of Dr Shand and her work.

Dr Ann Evans Applauded by the Accreditation Committee

Ann tendered her resignation from the committee at our last teleconference meeting after many years as a stalwart member and leader in this area. She has been responsible for supporting many candidates, particularly appreciating the difficulties for those who are working in smaller centres, while they hone their skills and gain accreditation as DSAC examiners. Her eagle eye in reviewing documentation and her commonsense approach has been invaluable to the committee. While she remains enthusiastic and supportive of the accreditation process, other environmental issues have captured her attention and her skills are now extending to airport noise control. I am certain, knowing Ann, that learning points for those involved will eventuate from this exercise and her community will be well served.

Thank you Ann, from all of us on the Accreditation Sub-committee, and best wishes for your new projects.

Dr Jane Batchelor
Chairperson
DSAC Accreditation Sub-Committee

Internet Safety - Lee Chisholm

What is NetSafe?

NetSafe – (The Internet Safety Group) is an independent not-for-profit organisation providing cyber safety and online security education for all New Zealanders. NetSafe works with children, parents, early childhood education services, schools, community organisations, businesses and individuals. NetSafe's aim is to educate all New Zealanders about safe, secure and responsible use of information and communication technologies. NetSafe has a staff of 10, and a wider consultative group (called The Internet Safety Group) which includes representatives from the Ministry of Education, educators, boards of trustees, the New Zealand Police, the Police Youth Education Service, the Judiciary, the Department of Internal Affairs, New Zealand Customs Service, community organisations, businesses, and parents.

NetSafe was founded in 1998, and its major concern was the protection of children and young people online. While NetSafe continues to focus on child safety, it now seeks to educate all New Zealanders about cyber safety and security, so they can safely and securely experience the many positives of communication technologies.

Cyberspace is accessed by mobile phones, gaming devices (like play stations and Xbox) and other information communication technologies (ICT), as well as computers. ICT has bought a huge range of benefits to us all, and some risks as well, including: access to anti-social content, computer security risks, copyright infringement, plagiarism, costs from uncontrolled usage, fraud and identity theft, legal and illegal pornography, unwanted sexual solicitation, grooming by sexual predators.

What do we do?

NetSafe provides a comprehensive website www.netsafe.org.nz addressing a variety of areas of safety and security online. Included is information on relevant research and findings, grooming, pornography and objectionable material. NetSafe also educates through presentations to a variety of audiences both in NZ and internationally. We have produced a Cyber Safety Kit for Schools and also one customized for Early Childhood Education Services. NetSafe runs a nationwide helpline on 0508 NETSAFE (0508 638 723) or queries@netsafe.org.nz

The NetSafe Contact Centre operates Monday to Friday 8am-6pm.

Relevant Issues

There are a number of current issues which stand out from either NetSafe's Contact Centre enquiries, our research, or both. The following will be of interest to DSAC members.

Young people are online. It is their social space, they can access it from a variety of sources, and it is as important to them as any offline communication. Parents and caregivers are most concerned about sexual solicitation online and sexual predators grooming young people in order to sexually abuse them. People can feel violated and abused from online sexual talk and images. It can feel as traumatic as physical assault. Both adults and young people can meet someone online and then go on to meet face to face and be at risk of sexual assault or child abuse.

Sexual groomers may be very well versed in how to locate vulnerable young people online, how to connect with them, engage them in a relationship and advance that relationship either via the dependency which has been established or through intimidation and fear. Young people can expose their vulnerability by the information they post online: information such as their isolation from family, their lack of friends, feelings of low self-esteem, depression, confusion about sexual identity etc.

A complicating issue can be young people who are seen by some to be complicit in sexual behaviour with adults in Cyberspace. They may falsify their age so they can join adult sites, talk about sex and send images or live webcam footage to strangers (or people known to them offline) and organize to meet with these online friends. Young people may have done this in return for gifts (a mobile phone, credit, money etc) and/or as part of their adolescent experimentation or curiosity and development of their sexual identity.

As with other adolescent behaviours, their cognitive and emotional development restricts their ability to assess risk accurately, particularly the possible long term consequences. So a young person may inflate their age in order to be on an online dating site, call themselves by a suggestive nickname, post a suggestive or sexy picture of themselves, become involved in one or more online relationships and meet the person for sex. Recent research from the US has shown that predators often don't need to lie about their age or their intent, as many young people are willingly (or unwittingly) becoming involved in such activity.

Unwanted sexual solicitation, online sexual abuse, sexual assault resulting from meeting someone face to face who had been first contacted online, are risks for adults as well as young people. These risks exist in the offline world however there may be additional issues with the online, like the shame of having developed a relationship very quickly online, betrayal after what may have been experienced as an intimate, trusting online relationship and maybe some stigma still attached to searching for and developing relationships online.

We receive many calls from adults and young people who have consented to the production of intimate photos while in a relationship, only to have those photos misused after the relationship ends. Photos are so easily posted on websites, social networking pages, emailed, sometimes with disastrous effects. Women have had intimate photos taken consensually by their then partner and subsequently mailed to all colleagues at work, family and friends.

It is important to remember that the majority of young people show a lot of resilience in dealing with unwanted contacts and that the majority highlight cyber bullying and harassment as their largest concern. Unfortunately, however, some young people report significant and distressing accounts of online grooming and sexual abuse.

Lee Chisholm
For more information contact me on leec@netsafe.org.nz or (09)353 0625

How can people get help?

For more information on sexual risks in Cyberspace visit our website www.netsafe.org.nz and contact us by email on **queries@netsafe.org.nz**

Phone the NetSafe Contact Centre and text bully line on
0508 NETSAFE (0508 638 723)

Bebo us: www.bebo.com/netsafe
Msn us: net_safe@hotmail.com

Te Ohaakii A Hine - National Network Ending Sexual Violence Together (TOAH NNEST) – April 2008 Newsletter Outline

The April TOAH NNEST Newsletter outlines the discussions and outcomes of their Steering Group Hui held on the 3-4th April in Auckland and provides some information on the Taskforce for Action on Sexual Violence.

A brief outline follows (the Newsletter in full can be emailed on request from the DSAC Office):

1. The main themes of discussion at the hui were the Governance Model, overall philosophy and constitution of the organisation, and the management of the co-ordinator.

2. Taskforce for Action on Sexual Violence terms of reference opening statement:

The Taskforce shall review the criminal justice system to determine how reform can increase the effectiveness of its responses to sexual offending and improve justice related outcomes for victims. In doing so it will address itself to the need to provide accountability for, and, deterrence and prevention of, sexual offending and the effect that increased prosecution and conviction rates would have on this. It shall also consider how reform can improve outcomes for victims of sexual violence, particularly with regard to minimising the traumatic impact of engaging in the criminal justice system, and maximising victims' experience of justice and resolution.

The following key priority areas have been defined within the terms of reference:

a) Prevention strategies and services incorporating attitudinal change and education, early intervention and crisis response to acute and chronic sexual abuse and assault
b) Recovery and support services for those who have experienced sexual violence
c) Treatment and management of offenders that reduces re-offending and increases community safety
d) The effectiveness of the criminal justice system responses to sexual offending (including reporting, investigation, legislation, evidential procedures, prosecution and conviction)
e) The responsiveness of the justice system to victims and improving outcomes for victims.

A work plan has been developed and each initiative on the work plan has a lead agency as well as partner agencies which include representatives from Government Ministries as well as Nga Kaitiaki Mauri and the Tauiwi Caucus of TOAH NNEST.

Creating Change in the Prevention of Sexual Violence - A Forum Hosted by the Wellington Sexual Abuse Network - 8th - 9th April 2008 - Hayley Samuel

I attended this forum, hosted by the Wellington Sexual Abuse Network, on the 8th and 9th of April in Wellington and found it to be fascinating and thought-provoking! A brief outline follows.

Day One – involved presentations and a panel discussion by academics whose research is influencing changes in thinking about sexual violence prevention (as below). The forum was attended by ministry officials and representatives from a number of NGOs in the sexual violence sector ranging from those working with survivors to offenders. I would estimate approximately 150 attendees.

Dr. Moira Carmody, Associate Professor & Acting Director, Research Centre for Social Justice and Social Change, University of Western Sydney
Moira has 20 years experience in all aspects of sexual violence prevention - sexual assault counselling, state and federal policy development, education programmes, research and publication. Her areas of expertise include non-violent education, sexual ethics, gender, sexuality, education and social policy, crime and non-violence. She presented on the project - "Developing ethical sexual lives", a three year study and pilot programme, promoting ethical and non-violent relationships between young men and women, run in collaboration with the New South Wales Rape Crisis Centre.

Dr. Nicola Gavey, Associate Professor, University of Auckland
Nicola's research is concerned with the inter-relationships between gender, power, and sexuality, and the inter-relationships of culture and psychology, with particular interest in equity and social justice. She presented on her research into the social and cultural conditions that contribute to rape and sexual violence and implications for prevention.

Dr. Melanie Beres, Postdoctoral Fellow, University of Auckland
Melanie's research interests are in the areas of sexuality, sexual violence and women's health. Following her experience coordinating a sexual violence prevention programme in Canada, Melanie has researched the negotiation of sexual activity in casual relationships, and is currently researching sexual negotiation between couples. She presented on the complexities of "consent" and its implications for preventing sexual violence.

Dr. Louisa Allen, Senior Lecturer, University of Auckland
Louisa's research interests lie in the areas of sexualities, sexuality education and gender; she has conducted research into senior school student's experience of sexuality education and the sexual culture of schools. Louisa presented on her research and its implications for sexual violence prevention.

Day Two – was a facilitated workshop and open discussion for NGOs in the sexual violence sector, on ideas from Day One and how we can work together on moving forward, locally and nationally, with primary prevention initiatives. Largely what came up was the need for more education for young people and parents – particularly around "ethical relationships".

The Wellington Sexual Abuse Network Education Project Report makes for an interesting read. I am happy to email copies to those who are interested.

Hayley Samuel
DSAC National Manager

Abuse Nurses Group for Support and Training (ANGST) Whanganui aka Renegade Nurses

Following a meet and greet session with one of our newly DSAC trained Whanganui GPs, namely Doctor Brian Scrimshaw, a volunteer based DSAC after hours Paediatric and Adolescent Nurses Roster of 1 registered nurse began on the 18 April 2007 with a twofold purpose of providing nursing care to sexually assaulted children and adolescents, and clinical nursing support to Dr. Scrimshaw. Word quickly got around about this fabulous opportunity to provide a DSAC service within the Whanganui region and this one nurse was joined on June 12th by a further 5 very keen and enthusiastic registered nurses for our very first DSAC after hours Nurses hui (meeting). Although the 5 RNs were not DSAC trained and had minimal experience in the specialty of child, adolescent and adult abuse care, all had either a professional background in child and or adolescent health, adolescent and adult sexual health, public health, Maori health and/or primary health care. All 5 Nurses were and still are enthusiastic, keen to learn and in addition unpaid to be part of the after-hours sexual assault roster for Paediatrics, Adolescents and Adults here within the Whanganui region.

I now introduce you to the fabulous 5 and their backgrounds.

- Joanna Heap MN, RN who has a child and adolescent health, public health and Education background
- Desiree Watt, RN who has extensive experience with Adolescent Health and currently holds 2 roles as a RN at the Whanganui Family Planning service and part time practice nurse for Whanganui Accident and Medical
- Dave Taylor, RN who has an extensive Rural Health, Plunket and Tamariki Ora Nurse background currently employed by Te Oranganui Iwi Health Authority
- Jo Barritt, RN who is an experienced Practice Nurse with an interest in working with children and adolescents
- Georgina Tauhopa-Melody, RN who works as a mobile Iwi Primary Health Nurse.

For our second hui we welcomed Grace Taiaroa, RN, who at that time worked as a Public Health Nurse however now has the role as the WDHB, HEHA district coordinator. We are lucky to have the support of our fabulous WDHB Paediatrician, namely Doctor Anagha Jayakar, who completed the Paediatric and Adolescent DSAC training in 2007. Mention must also go to David Montgomery, Director of Paediatrics Whanganui DHB for his continual support and encouragement.

Recently, with support from the work places Te Oranganui Iwi Health Authority, Iwi Rangitaane and the Whanganui DHB Public Health Centre, and funding support from the WDHB Funding and Planning, we were able to send 3 ANGST Whanganui Registered Nurses and an additional 2 WDHB Paediatric Ward based Registered Nurses to the Paediatric and Adolescent DSAC Training held in April 2008. Following this training we welcomed more members to our team; Janene Louwrens, RN who is also the Charge Nurse Leader of the Whanganui Paediatric ward and Jacqui Pennefather, RN also based in the Paediatric ward. More recently, with funding support again from the WDHB for 1 RN and additional funding support from the Whanganui NZ Police for 2 RNs, the remaining 3 RNs completed the DSAC adult training in May 2008. So now I am proud to say that we have an amazing ANGST Whanganui team of 9 DSAC trained aka Renegade Registered Nurses of Whanganui.

Current Issues to overcome

1. All RN's are working as volunteers as there is no established funding stream
2. No Paediatric or Adolescent friendly environments to carry out assessments
3. No Crisis Counselling Service
4. No Child, Adolescent Protection Coordinator
5. No designated child and adolescent setting in Whanganui
6. How to ensure that all 9 Nurses maintain an acceptable level of competence in Sexual Assault Management

Mars Delamere
DSAC After Hours Nurse Coordinator
Whanganui

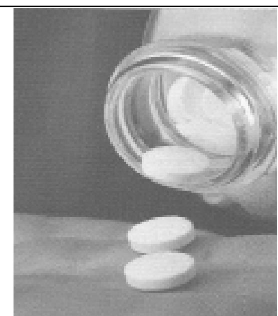
Azithromycin

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, Victoria Street West, AUCKLAND 1142

To order your supplies for the next 6-12 months you can either write, email: dsac@ihug.co.nz or fax: 09 376 0790



College of Practice Nurses Annual Conference, Tauranga 16th - 18th May 2008 - Dr Faye Clark

It was with very great pleasure that I attended this well organised gathering and presented an overview of the importance of Partner Abuse Recognition and Response training for all in primary health. The session I was allocated was on Saturday afternoon and there was a full attendance of more than 200 nurses who were willing to lend me their ears. The aim was to encourage nurses to go back to their PHOs and request access to training. I understand there have been some contacts with the DSAC office already: these may prove to result in opportunities to provide training in a variety of areas.

It was a glorious weekend and the attendees had an excellent programme – I enjoyed a session by Associate Professor Amanda Oakley on red rash, and a wonderful presentation by Emeritus Professors Nan Kinross and Norma Kirk, who were the initiators and developers of the university degree in Nursing at Massey University in the early 1970s. What inspiring, remarkable women they were and are!

Thank you to the organising committee, especially Rosemary Minto and Julie Cowley, for the invitation to be a guest speaker, and for the warm hospitality.

Dr Faye Clark
DSAC Partner Abuse Intervention Trainer
Auckland

Domestic Violence as a Human Rights Violation: New Zealand Under Scrutiny by Fordham Law School, New York - Dr Faye Clark

L-R Back: Abisola Fatade, Emily Wei, Justin Bernstein, Professor Chi Mgbako, Proffesor Paolo Galizzi; Front: Dr Kalash Deva, Dr Faye Clark

On Monday 12 May Kalash Deva and I were pleased to host 2 professors and 3 postgraduate students who were conducting some research for the Leitner Centre for International Law and Justice, Fordham Law School under their annual Crowley Mission funding.

We met them following the original scoping visit by Jorge Contesse earlier in the year. His interest in studying New Zealand (as opposed to a 3rd World country) was sparked by contacts with a New Zealand official at the United Nations who had brought him into discussion with Dr Pita Sharples – who had then suggested he contact DSAC as a key agency. (Thank you Dr Sharples!)

It was a pleasure to talk to Professors Paolo Galizzi (originally from Verona) and Chi Mgbako and the students Justin Bernstein, Abisola Fatade and Emily Wei about the issues surrounding Recognition and Response to Partner Abuse from the perspective of general practitioners in New Zealand – the lack of serious undergraduate training in the area, the sporadic post graduate opportunities for training and the fairly recent history of an officially funded programme being available for any teaching at all in Primary Health Care or DHBs on this important issue that affects health.

This group of 5 were part of a team of 14 spending 2 weeks in New Zealand, in which time they were covering Whangarei, Auckland, Hamilton, Wellington, Nelson and Christchurch. They had already spent that day at Preventing Violence in the Home – a key national as well as local agency – and were going to be talking to victims, to law and justice stakeholders, to government ministers, to refuge workers and leaders and to perpetrators. Their intention to work hard was obvious – we enjoyed a meal at Portofino in Mission Bay but it was very much a "working meal". I hope they had the chance to sample some of our fine wines elsewhere as this was not part of the Schedule on the 12th!

Upon conclusion of the study the Leitner Centre will publish its findings, submit them to a scholarly journal and make them available to human rights advocates and policy makers.

It should make for very interesting reading – seeing ourselves as others see us….

Dr Faye Clark
DSAC Partner Abuse Intervention Trainer
Auckland

Working with Child Sexual Abuse: Strengthening and Informing Practice, Auckland 30th April - 2nd May 2008 - Hayley Samuel

I presented a session on DSAC and the National Sexual Abuse Assessment and Treatment Service at this regional symposium hosted by SAFE.

I also attended the following sessions:

Child Sexual Abuse on Trial: The Jury Research Project – Dr Suzanne Blackwell

Dr Blackwell is a clinical psychologist. She was previously the Senior Psychologist, and then Consultant Psychologist to the New Zealand Justice Department Psychological Services and involved in assessment and treatment of sexual offenders. She has also assessed and treated children and adults with child sexual abuse trauma histories and given expert evidence in criminal trials in relation to child sexual abuse. In early 2004 she took leave from fulltime private practice to undertake the Jury Research project which has been the basis of a PhD thesis.

Currently, she is in private practice as a clinical psychologist and is an Honorary Research Fellow (Psychology) at the University of Auckland, a researcher in the "Child Witnesses in the Criminal Justice System" research project funded by the Law Foundation and administered by the Institute of Public Policy (AUT).

She is an editor of the forthcoming third edition of "Psychology and the Law: A Handbook" and is the Coordinator, and a member, of the Medical Council of New Zealand team of specialists which conducts the assessments of medical doctors who have been found guilty of sexual misconduct in relation to their patients. In addition to clinical work she accepts briefs for opinions, reports and expert witness testimony.

Child sexual assault prosecutions in New Zealand are typically committed to trial by jury. This research project (2004-2006) investigated whether jurors have adequate knowledge or subscribe to common misconceptions about children and child sexual abuse that are exploited in the conduct of trials. Empanelled jurors from 23 criminal trials were interviewed post trial. Results indicated that some jurors had accurate knowledge, others subscribed to common misconceptions and others expressed a lack of knowledge.

The results of this research raise serious concerns with respect to whether the adversarial system of law is both appropriate and ethical in relation to the disposition of charges of sexual offences against children.

You can find out more about the results of this research project on Friday, 1st August 2008 at the Rolleston Theatre in Christchurch. Dr Blackwell is an invited guest speaker at the DSAC 4th Combined Australia and New Zealand Meeting on the Medical Assessment of Sexually Abused Children and Adolescents. This is the first session of the meeting and because of the relevance of the topic that Dr Blackwell is speaking on DSAC would like to invite colleagues, both medical and non-medical, working in the field of sexual abuse to attend. To register, or for further information, please contact the DSAC Office.

Not Just Old Men in Raincoats: Children Who Engage in Sexually Abusive Behaviour – Clare-Ann Fortune & Ian Lambie

Clare-Ann, a clinical psychologist at the regional youth forensic service, Kari Centre, Auckland DHB, in conjunction with Dr Ian Lambie, Senior Lecturer in Clinical Psychology at the University of Auckland, presented research data on children who engage in sexually abusive behaviour from a recent outcome study of specialised community based treatment programmes in New Zealand.

CYF funded this study. Information was gathered via a file audit.

Demographics:

- The study involved 35 children (all male) referred to treatment programmes over a nine and a half year period.
- The children were aged between 8 – 13 years old (mean age = 11.6 years).
- Ethnicity:
  - 51% NZ European
  - 26% NZ Maori
  - 23% Pacific Island
- Referrals: - these children were referred to SAFE programmes in Auckland, Wellington and Christchurch. Referrals were made by:
  - CYF (89%)
  - NGOs (6%)
  - Family/whanau (3%)
  - Schools (3%)
- Mandate to attend:
  - 34% of these children had a CYF directed mandate to attend the programme
  - 66% were not mandated to attend.
- Living situation at the time of referral:
  - 63% of the children were living with their family
  - 37% were in non-family care (boarding schools etc.)
- Education:
  - 91% were currently at school however:
  - 31% had been expelled or suspended
  - 14% had a history of truancy
  - 17% had experienced bullying (were the victim of bullying)
- Abuse Histories:
  - 43% had experienced sexual abuse (2/3 of the perpetrators were adults, 20% adolescent perpetrators and 7% were child perpetrators)
  - 37% had experienced physical abuse by adult perpetrators

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- Up to 23% had experienced other abuse or neglect
- 17% had experienced both sexual and physical abuse
- Some had been victims of sexual abuse over a number of years

- Socialisation & activities:
  - 37% had social skills deficits
  - 43% had poor peer relationships
  - 31% were socially isolated
  - 26% had low self esteem
  - 57% played sports
  - 54% had hobbies
- Co-morbid problems:
  - 54% behavioural problems (anger, aggression, violence, conduct disorder)
  - 46% mental health problems (PTSD, attachment issues, depression, anxiety)
  - 20% suicidal ideation or deliberate self-harm
  - 6% substance misuse

Characteristics of the offending:

- Age when the first offence was reported:
  - Range 4 – 13 years
  - Mean age = 9.4 years
- Number of identified victims:
  - Range 1 – 13 victims
  - Mean = 4.6 victims
  - Median = 3 victims
- Gender preference:
  - 23% male victims only
  - 37% female victims only
  - 40% male and female victims
- Offence type preference:
  - 34% 'hands on' only (included 67% sexual violation / indecent assault, 10% rape, 9% oral contact)
  - 26% 'hands off' only (eg stealing underwear, peeping, sexualised language etc)
  - 40% both 'hands on' and 'hands off' offences
- 129 victims were involved over the 35 children in the study
  - 34% female victims
  - 64% male victims
- Victim age range:
  - 17% 0 – 4 years
  - 40% 5 – 9 years
  - 30% 10 – 12 years
  - 8% 13 – 17 years
  - 6% adults (the adults were more likely to be victims of the 'hands off' offences)
- Relationship of victim:
  - 25% immediate family members
  - 70% known to the offender but not immediate family (e.g. half/step siblings, cousins, aunts)
  - 2% strangers (neighbours, other children in care, teachers, tutors)
- Frequency of incidents:
  - 56% once
  - 22% 2 – 5 times
- Strategies:
  - 54% no strategies known or reported in file
  - 17% of the offenders used force
  - 23% used grooming such as a game e.g. 'doctors and nurses'
  - 17% used verbal or physical threats
  - 11% used coercion

Other reported behavioural problems (non-sexual):

- 31% dishonesty
- 9% assault/violent offences (includes possession of offensive weapons, robbery etc)
- 9% property damage

Family characteristics:

- Parent's marital status:
  - 60% divorced/separated
  - 17% married/defacto
  - 14% never married
  - 6% parent/s deceased
  - 3% unknown
- Family co-morbidity (includes immediate and immediate extended family):
  - 17% sex offender (charged)
  - 17% general offender
  - 26% mental health issues
  - 11% suicidal ideation/attempts
  - 29% substance misuse
  - 43% domestic violence (witnessed)

Conclusions:

- The children involved in this study presented with a range of issues
- They generally came from chaotic and multi-problem families
- The children were engaging in significant sexually abusive behaviours including victimising children who were peers and/or relatives

Service provision:

- Supports are needed for programmes to provide services for children who are engaging in sexually abusive behaviours
- There needs to be education and awareness amongst the public; statutory agencies, service providers and other organisations
- There needs to be support for the inclusion of family in the treatment programmes and family-based interventions

Navigating the Minefield: Controversy and Challenge in Reunifying Adult Sex Offenders and Their Families – Nola Forsyth (SAFE), Martin Putt (SAFE), Anthea Randel (Auckland Sexual Abuse HELP Foundation)

This was an interesting panel discussion on the many risks, challenges and responsibilities that treatment providers, victim agencies, statutory agencies, child protection services and families themselves have when considering reunifying adult sex offenders and their families.

In brief, if an adult sex offender is on a treatment programme they must be separated from any <16 year olds in the house. Before reuniting the offender and their family the following must be considered:

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1. Victim/survivor readiness
2. Offender must admit full responsibility for their past offences
3. Offender has to explain their cycle of offending and their safety plan to their partner

<u>Chaos and Confusion: Child Sexual Abuse and Stockholm Syndrome – Dr Shirley Julich</u>

Abstract – Adult survivors of child sexual abuse have seemed reluctant to report the sexual victimisation they were subjected to as children. This would not surprise professionals working in this area. The same phenomenon has been observed with victims of domestic violence. They too are reluctant to disclose within an intimate relationship. A similar intimate relationship enables the sexual abuse of children. The child, powerless to stop the sexual abuse, utilises a variety of strategies to enable his/her survival. The same survival techniques have been observed in hostages who have been held captive: a phenomenon which is usually referred to as the Stockholm Syndrome. The contradictory, bi-directional relationship central to this syndrome provides valuable insights for people working in the area of child sexual abuse.

Dr Julich is a senior lecturer at Auckland University of Technology where she is Manager for Quality Assurance in the Centre for Business Interdisciplinary Studies and Programme Leader for the Restorative Justice Centre. Her doctoral research explored restorative justice from the perspective of adult survivors of child sexual abuse.

Dr Julich's research investigated whether adult survivors of child sexual abuse would support restorative justice. In-depth interviews were conducted with 18 female and 3 male adult survivors of childhood sexual abuse. All but one of the survivors had experienced repetitive contact sexual abuse in the context of their family or social system.

Reporting:

Survivors of sexual abuse report that a sense of justice is integral to their journey of recovery and yet many do not report. It is generally assumed that child victims of sexual abuse are unable to report because of lack of power and their position in the family. Dr Julich's research explored the question – if justice is a priority for adult survivors, why do they appear to reject both the criminal and restorative justice processes?

Possible answers:

- Bystanders (those who were unable to protect the child in the first instance) participate as the "community of interest" in a restorative justice conference
- Deep-seated distrust of the traditional criminal justice system
- A sense of hopelessness "nothing will work in my family or circumstance".

Stockholm Syndrome & Child Sexual Abuse:

- Children are not typically thought of as hostages but they can be victims and they can be held captive
- We accept that hostages can develop Stockholm Syndrome
- Children, particularly those subjected to ongoing child sexual abuse, are really vulnerable to Stockholm Syndrome

Precursors to Stockholm Syndrome:

- Perceived threat to survival and the belief that the abuser is willing to carry out the threats that they use
- The victim's perception of some small kindness from the abuser within a context of terror
- Isolation from perspectives other than those of the abuser
- Perceived inability to escape.

The victim needs to be exposed to these precursors for sometime for the syndrome to develop.

Cognitive distortions that occur as part of Stockholm Syndrome:

- Victims believed the abuser needs their help
- Victims see the abuser as a victim who only needs to be loved
- Victims believe that they are the only person who is able to understand the abuser
- Victims want to protect the abuser and believe that they are the only ones who can

Implications of Stockholm Syndrome:

- Victims will be in varying stages of the recovery process
- They will appear ambivalent and possibly contradictory at times
- They require access to an independent support person of their choice
- Need to be aware that this support person could be a bystander (defined in this instance as "those who were unable to protect the child in the first instance")
- Victims may not be confident that bystanders and outsiders can contribute objectively
- Bystanders can be victims too and might suffer the effects of Stockholm Syndrome
- Bystanders can have different perspectives of the abuser to the victim
- Bystanders might exert considerable pressure on the victim to withdraw allegations or to agree to conference outcomes
- Outsiders and bystanders may minimise the abuse
- Outsiders act as role models (could be positive or negative)
- Abusers can be highly skilled at maintaining an elaborate construction of denial
- Abusers will attempt to maintain and exploit existing bi-directional relationships
- Professionals are not immune to Stockholm Syndrome and need access to skilled supervision

<u>Project Restore: Assessing 'Risk and Readiness' of Participants in Restorative Justice Processes for Sexual Offending – Fiona Landon and Maurice Jennings</u>

Project Restore is a pilot programme exploring the use of restorative justice processes for sexual offending. A key ingredient to the success of the programme is assessing risk and readiness of potential participants both to enter into the process and to tailor the process to match their capacity and that of the systems within which they operate. This session

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explored the dilemmas involved both within the constraints imposed by the 'justice system' and the need to provide a 'survivor driven' process that empowers survivors to gain experience of both justice and healing.

A pre-requisite for this process to be considered is that the offender must be in treatment. The survivor is also encouraged to engage in therapy as both the offender and the survivor's therapists are involved in the restorative justice process.

What is survivor driven?

- A tailor made process paced to the survivor's needs
- Survivor is actively seeking the process
- Informed consent given
- Survivor's needs prioritised
- Survivor's decision to undertake the process made for her own reasons i.e. not to please offender or other family members
- Preparation of offender to maximise survivor needs

Other issues:

- Impartial facilitation
- Can it ever be a survivor driven process when coming from offender court process i.e. survivor often finds it difficult to believe that the offender wants to really engage in the process as opposed to a "get out of jail free card"
- How do we address the impacts of the timing:
  - of the court processes
  - offender treatment programmes

Survivor assessment:

1. Capacity
   - Internal self capacities – where are they at in their journey at the time of the intervention?
   - External resources – social support
2. Expectations
   - What do they want to say and why?
   - What do they want from the offender and who do they want involved in the process?
3. Needs
   - What is the nature and amount of preparation required?
   - Which parts of the process are appropriate and what stage?
   - Key relationships strengthening eg non-offending parent

Tailoring process:

- Pacing process to survivor needs/capacity
- Exploring options that will address needs
- Identifying any key relationships that need strengthening first
- Encourage survivor to engage with a therapist to provide a place for emotional processing which may be triggered by the restorative justice process

What the Project Restore Team have learnt so far:

- How to bring three ways of working together:
  - Survivors, sex offenders and the culture and practice of restorative justice
- Ways of making initial contact with the offender when the process requested by the survivor (if the sexual assault was not reported to the Police) – who, how and when is best? (Also encourage offenders to seek their own legal advice prior to engaging in the restorative justice process)
- Multi-layered approach to restorative justice process:
  - offender treatment prior to restorative justice conference, initial work with family
- Explored impact of disclosures in restorative justice meetings:
  - Police investigation is not weakened if it is called a therapeutic process
- Public Interest Community – Common Law (Bill of Rights Act), can't be seen to condemn yourself out of your own mouth in unfair circumstances (don't want to weaken Police case)

Restorative justice meeting with the offender:

- The offender therapist needs to:
  - Assess the perpetrator's motivation and responsiveness to the restorative justice process
  - Gauge the client's capacity to make an appropriate apology
  - Discuss therapy options and gauge client's willingness to engage in therapy
  - Expectations of the restorative justice process and therapy
  - Additional issues and reparation, apology, remorse?
  - Know the grooming techniques utilised by the offender so that they are not used in the restorative justice process

- In the week leading up to the facilitated meeting the offender therapist needs to discuss the following points with the offender:
  - Expectations, hopes and fears about the meeting
  - Clarifying the perpetrator's role during the meeting
  - Coaching on effective listening
  - Clarifying the offender therapist's role during the meeting
  - Answer any questions

- During the facilitated meeting the offender therapist's role includes:
  - Observing and monitoring the perpetrator
  - Being prepared to interrupt the perpetrator where the client's response is inappropriate
  - Coaching the offender client
  - Providing information to the whole group
  - Providing support to the survivor
  - Debriefing with the offender client post meeting

Contraindications:

- Survivor motivation
- Offender client denial of abuse
- Offender client psychopathy
- If the offender client has no empathy or capacity to develop empathy for the victim
- Offender client drug and alcohol use
- Severe or poorly controlled mental health issues

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The Good the Bad and the Ugly – The Impact on Therapists of Working with Sexual Offending – Martin Putt and Wendy Howlett (SAFE)

This session drew on the work of Lesley Ayland who researched the experiences of therapists who work with those who sexually abuse. The study was based on in-depth interviews with seventeen therapists who work with people who sexually abuse from both community-based programmes and from the Department of Corrections in New Zealand.

The Balancing Act: Therapists' Experience of Working with Clients with Abusive Sexual Behaviour - Lesley Ayland, Youth Programme Clinical Manager, WellStop

A theme that emerged in Lesley's research was that therapists who work in this field:

• Actively seek challenge and variety in their work;
• Actively engage in balancing the challenging, and frequently negative aspects of the job, by using a range of coping strategies and focussing on the positive aspects of the work.

Lesley Ayland found that therapists appeared to have difficulty with five different aspects of their work:

• Working with difficult clients and situations
• Hearing about sexual abuse
• Organisational and logistical issues and stresses
• Personal issues and responses
• Isolation

There were also five more positive aspects of the work that either contributed to therapists gaining job satisfaction, or that assisted them to cope with the negative aspects of the work.

• Positive attitude and approach
• Understanding and perspective taking
• Clear boundaries
• Self-care
• Support and supervision

Five different stages emerged from the data that therapists appeared to go through over the course of working with people with sexually abusive behaviours:

1. Gaining Balance
2. Maintaining Balance
3. Losing Balance
4. Regaining Balance
5. Stepping Off the Balance

Stage 1 – Gaining Balance

• Therapists went through a process of Gaining Balance when they commenced working in the field.
• About half of the therapists reported having experienced a strong response such a shock, anger, fear or anxiety.
• The other half who did not appear to have strong feelings differed in that they had no prior experience working in related fields (e.g. sexual abuse survivors or violent offenders) and had not yet heard anything that was disturbing.
• Participants identified the most important coping strategy for Gaining Balance to be receiving good support, in particular, for agencies to provide a range of support structures, especially good supervision.
• Participants also considered academic training in the techniques used to work with people with sexually abusive behaviour helpful.

Stage 2 – Maintaining Balance

This is the stage where therapists experience the 'ups and downs' of their work and cope with the negative aspects of the work by using coping strategies, or by focusing on the positive aspects of their work.

Stage 3 – Losing Balance

This happened in two main ways:

a) Falling off Balance:

• Tended to be more short term and therapists recovered from it within a reasonably short period of time.
• The traumatic responses that therapists described were very similar to the concept of Secondary Traumatic Stress (Figley 1995). For example, nightmares, and intrusive thoughts of the abuse, nausea, dissociation and distress).

b) Overloading the Balance:

• Occurred when there was a build up of stress or change in people's perceptions so that over time therapists became overloaded.
• Burnout-symptoms such as exhaustion, emotional depletion, poor work performance etc
• Changes to normal life - Longer-term changes, such as changes in sexual thoughts, feelings and behaviour, sense of safety in the world and in their relationships with other people.

Stage 4 – Regaining Balance

• This stage involves the use of coping strategies to get back to a point of balance
• The strategies that therapists described were the same strategies that were used to "maintain balance"; however there was more emphasis on the need for support. For example, being able to take more time off for extra supervision.
• There was some indication from experienced therapists interviewed in this study that once therapists have gained the balance that they tended to go through cycles of maintaining, losing and regaining the balance.

Stage 5 – Stepping off the Balance

• Three therapists in this study stopped working primarily with people with sexually abusive behaviour although they were still somewhat involved in different capacities. One left due to burnout, and two left because of some dissatisfaction or to seek new challenges.
• Most therapists indicated that they did not plan to continue in this work forever, primarily because they felt it was not healthy

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to do so.
• This part of the model requires further investigation as the focus of this study did not include therapists who had left the field.

The data revealed the following gender differences:

…. "Am I safe"
Women therapists tended to be more concerned about safety issues, both their own personal safety and the safety of those around them. They spoke of modifying how they dress and being more likely to worry whether their children had been abused.

…. "Am I like them"
Men tended to be more concerned about their own behaviour, beliefs and attitudes. Male therapists tended to be concerned that their sexual attitudes and behaviour might be similar to the clients, especially when they listened to the clients disclose their sexual behaviour and attitudes.

Implications for therapists:

• Preparation prior to taking on a role in the field was considered important.
• Therapists stated that therapists require considerable life experience of having dealt with difficult situations.
• Need to be very clear about their own beliefs and values and to have largely resolved any issues of personal difficulty.
• Therapists would benefit from having previously worked in related fields such as sexual abuse survivors, with people with addictions or with other offenders prior to working in this field.
• To have established support networks and a lot of self-care strategies.
• Some therapists in the study were not getting personal supervision but those that did indicated that it was a very important coping strategy.

Implications for Agencies:

Work Practice

• Therapists need to have a variety of tasks and roles within the agency, such as a mixture of clinical work, administration and research or programme evaluations and development.
• Within the clinical work therapists appeared to need a balance of doing assessments, individual and family and group work.
• Therapists' roles need to be sufficiently challenging so therapists have a sense of satisfaction, but not so challenging that they feel overwhelmed or overloaded. There needs to be agreement between staff and management as to what constitutes a full caseload.
• Therapists need the flexibility to structure their day and week so that they have breaks between intensive pieces of therapeutic work.
• Therapists also need planning time and time to debrief after they have seen clients, groups and family sessions.
• Therapists benefited from having "change-over points" between pieces of work. For example the use of ritual or more informal change-over points such as having a cup of tea.
• Therapists should be discouraged from working alone in buildings and to co-work where necessary.
• Community based therapists advocated for working part-time, however therapists in prison-based programmes or for corrections did not appear to favour part-time work.
• Therapists needed to take regular breaks and time away from work. Employment contracts need to include generous provisions for annual leave and domestic or sick leave. The provision of stress leave may also be required, especially after doing very intense work or dealing with major crises.

Work Culture

• Support for staff and respect for boundaries are two important aspects of a positive work culture.
• Therapists need to be able to self-disclose and discuss personal feelings and experiences at work with colleagues and supervisors. Therapists need to develop relationships with colleagues that fosters an atmosphere of openness.
• It is important for managers to view any difficulty that staff have in coping with the work as a normal process of the Balancing Act rather than pathologising their reactions.
• Therapist should not work long hours with difficult clients, go home at a reasonable time and be able to decline to work with particular clients.

Provision of Support and Supervision

This study highlights the importance of both clinical supervision and personal supervision (about the therapist's own personal processes relating to the work and the issues that arose in their own lives).

The session ended with the following quote: "We are never really expert …we are only curious people struggling to understand suffering and overcome it" *Brandt Steele in Juvenile Sexual Offending Eds.*

Hayley Samuel
DSAC National Manager

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THE MEDICAL MANAGEMENT OF SEXUAL ASSAULT SIXTH EDITION 2006

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 6th edition is significantly different from the 5th edition and has been reorganised into 3 main sections. Not all subsections have been fully updated for this edition and these will be added to the online manual as they emerge. Until all sections have been updated, some cross referencing will be inaccurate.

Section A contains practical guidelines for forensic examination and medical care of adult victims of sexual assault. For ease of use, references have been kept to a minimum. Forms and templates that can be used in your clinical situation are marked with a printer icon.

Section B contains guidelines for children and adolescents.

Section C contains important reference material.

Note that previous appendices are now included in the main body of each individual section.

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.

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DSAC Diary of Events 2008/2009

DSAC is a RNZCGP CME Registered Special Interest Group

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DSAC Advanced Paediatric Training Course and 4th Combined Australia & New Zealand Meeting on the:

MEDICAL ASSESSMENT OF SEXUALLY ABUSED CHILDREN AND ADOLESCENTS

Special Guest Speaker:
Dr Lori Frasier

Medical Director of the Medical Assessment Team at the Center for Safe and Healthy Families, Primary Children's Medical Center, Salt Lake City, Utah, and a Professor in the Dept. of Pediatrics at the University of Utah School of Medicine. Dr Frasier is on the board of Directors of the American Professional Society on the Abuse of Children (APSAC) and has been appointed to the American Board of Pediatrics, first sub board in Child Abuse Pediatrics.

NZ Guest Speakers:

Suzanne Blackwell, Clinical psychologist in private practice and Honorary Research Fellow (Psychology) at the University of Auckland.
"Child Sexual Abuse on Trial: The Jury Research Project"

Suzanne Alliston, Associate Clinical Team Leader, STOP Adolescent and Children's Programmes, Christchurch.
"Adolescent Sex Offenders"

VENUE:
1 August 2008
Rolleston Lecture Theatre,Ground Floor, Christchurch Campus, University of Otago School of Medicine (sits in front of Christchurch Hospital), 2 Riccarton Avenue, Christchurch

2 - 3 August 2008
Oncology Lecture Theatre, Oncology Department, Christchurch Hospital, Riccarton Avenue, Christchurch

OVERSEAS SPEAKER

Dr Marylene Cloitre

"Psychotherapy for the Interrupted Life:Treating Adult Survivors of Childhood Abuse"

Auckland - Monday 20th October 2008
Wellington - Wednesday 22nd October 2008
Christchurch - Friday 24th October 2008

OVERSEAS SPEAKER

Dr Ellert Nijenhuis

"Dissociation of the Personality and Childhood Traumatization: Theory, Research and Treatment"

Auckland - Friday 13th & Saturday 14th February 2009
Wellington - Wednesday 18th & Thursday 19th February 2009
Christchurch - Monday 23rd & Tuesday 24th February 2009

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 preferrable so as to reduce the possibility of error in transcription.

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