true relationships & reproductive health

TRUE SUPPORT SERVICES HUB FINAL REVIEW REPORT

Griffith UNIVERSITY

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Table of Contents

Background

A national snapshot of sexual violence experience

The following brief overview of current knowledge on sexual violence in Australia is primarily drawn from for the following sources: The Australian Bureau of Statistics' *Personal Safey Survey 2021* (ABS, 2022); and the Australian Institute of Health and Welfare's Family, *Domestic and Sexual Violence* (AIHW, 2022).

Experience of sexual violence

The national *Personal Safety Survey 2021* reveals that 14% of people aged 18 years or more had experienced sexual violence since the age of 15. It also reveals significant gender differences, with sexual violence experienced by a higher proportion of women (22%), compared to men (6.1%).[1]

Further, women were 31 times as likely to experience sexual violence perpetrated by a male, than a female.[2] Women were more likely to have experienced sexual violence perpetrated by a person known to them (20%),[3] compared to perpetration by a stranger (6.1%).[4]

The ABS (2023) also reports that "women who identified as gay, lesbian, bisexual or who used a different term such as asexual, pansexual or queer were more likely to have experienced sexual violence (13%) than women who identified as heterosexual (2.4%)." However, in nearly all (98%) of the cases of sexual violence again women in both groups, the perpetrator was identified as a male.

Reports to police

In the year 2022, there were 32,100 sexual assaults recorded by the ABS Recorded Crimes -Victims data[5] in Australia: most victims (84%, or 5 in 6) were

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[1] The PSS defines sexual violence to include assault and/or threat. Of the 22% of women who experienced sexual violence, 20% experienced sexual assault, and 5.5% experienced sexual threat. Of the 6.1% of men who experienced sexual violence, 5.1% experienced sexual assault, and 1.4% experienced sexual threat. Note: The ABS advises this figure to be used with caution as it has a relative standard error of 25% to 50%.

[2] Citing ABS, 2023a, AIHW notes that 22% of women experienced sexual violence perpetrated by a male, compared to the 0.7% of women who experienced sexual violence perpetrated by a female.

[3] Including a cohabiting partner (6.1%), a boyfriend or date (6.3%), a male neighbour or acquaintance (5%), and a male friend or housemate (4.9%).

[4] Data regarding relationship to the perpetrator is not available for men, due to the relative standard error in the statistical analysis (a consequence of relatively small number of men experiencing sexual violence across the different relationship types).

[5] The ABS Recorded Crimes – Victims database and the ABS Recorded Crimes – Offender database collect data on sexual assaults recorded by police across Australia,

females. The rate of recorded sexual assault cases for females was 206 per 100,000, compared to the rate of 39 cases per 100,000 for males.

The ABS data base shows a 43% increase in sexual assault victimisation rates for women, and a 51% increase in victimisation rates for men, as reported to police in the period between 2010 and 2022. A 15% increase in reports of female victimisation occurred between 2020 and 2021; and between 2021 and 2022, a 16% increase in reports of male victimisation occurred.

The most likely explanations for the apparent increasing trend for both men and women to report sexual assault to police, include increased community education and school-based programmes, the #MeToo movement, high-profile cases of sexual assault garnering unprecedented media attention in Australia, and changes in policing and the criminal justice system more broadly. However, sexual assault remains an under-reported crime, as evidenced in the latest *Personal Safety Survey*.

The *Personal Safety Survey 2021* reveals that only 8.3% of the most recent cases of women's victimisation by a male perpetrator were reported to police.[6] Of those, 7.7% were reported by the victim-survivor themself.

Sexual assault related hospitalisations

The Australian Institute of Health and Welfare (AIHWb) report that nationally there were 280 hospitalisations resulting from sexual assault in 2021-22. Females comprised the majority (93%) of hospitalised victim-survivors. Just fewer than one-third (29%) of people hospitalised following sexual assault were aged 25-34 years. People aged 15-19 years accounted for 17% of hospitalisations, followed by people aged 20-24 and those aged 35-44: each of these two groups comprised 16% of hospitalisations. The AIHW reports that both the gender and age distribution of sexual assault hospitalisations has remained relatively stable between 2017-18 and 2021-22.

The perpetrator of sexual assaults resulting in hospitalisation was most commonly recorded as "unspecified person", however, 23% of females reported that the perpetrator was a "spouse or domestic partner" (AIHW). The AIHW further report that no males who were hospitalised following sexual assault identified this category of perpetrator.

There is no obvious reason to believe that there would be any statistically significant differences for the Central Queensland region compared to the

[6] The PSS asks about the most recent incident of sexual assault by a male perpetrator in the last 10 years.

national profile presented above. However, it would be useful to gather and analyse local police and hospital administrative data for the further development of a regional response to sexual violence.

Nationally, time related sexual assault data are divided into reports of sexual assault made within 12 months of the incident; and reports of sexual assault made more than 12 months after the incident (ABS, AIHW).

The True Support Services Hub pilot

In mid-2023, True was awarded $150,000 under Category 2 of the Queensland Department of Justice and Attorney-General's (DJAG) *Keeping Women Safe from Violence* (KWSV) grants program. Category 2 grants were "for larger programs (including an outcomes evaluation and wider scope, which might include confirmed partnerships, higher participation, wider geographic distribution throughout Queensland and/or potential project longevity)" (DJAG grant application form). The KWSV program provided one-off funding for a period of one year.

True's successful grant application proposed the establishment and evaluation of the True Support Services Hub (TSSH), piloting a community-based response to acute sexual assault. The aim of the pilot was to provide "a seamless, supportive pathway of support to women who have been sexually assaulted, and to apply and evaluate screening and response protocols for responding to reproductive coercion" (True grant application). The model co-located the services of True's Forensic Nurse Practitioner and Sexual Assault Counsellor, and the Queensland Police Service's Criminal Investigation Branch (CIB) in a community setting, thus avoiding the additional trauma of attending the hospital emergency department for a forensic examination, and the police station to give a statement.[7]

The DJAG grant opportunity had come to the attention of the True CEO (who at the time had recently commenced in the position) not long before applications closed on 25 February 2023. The CEO, who has extensive experience in the

[7] The TSSH model specifically aims to support victim-survivors of sexual assault by collecting and storing forensic evidence for use in a formal complaint of rape or sexual assault to police immediately or at some point in time in the future, should they wish to do so. This approach facilitates victim-survivor choice in response to sexual assault, when they are ready to exercise their right to choose a course of action regarding a formal complaint and police intervention.

violence against women sector both in the community services sector and in government, prepared and submitted the application by the due date.

Summary of the literature

Sexual violence against women is an important and pervasive issue affecting millions globally, with severe physical, psychological, and social ramifications. The immediate response following sexual assault is important to prevent further traumatisation to the victim survivor and begin recovery. Services sought in the immediate to short-term aftermath of sexual assault may include forensic examination and general medical attention, trauma counselling/psychological assessment, police reporting and initiation of legal proceedings. This process can be complex and logistically difficult to navigate, acting as a further deterrent to timely reporting.

A coordinated response which integrates multidisciplinary, trauma-informed care may be able to address these logistical challenges and enhance access and uptake of support services. This brief summary of the literature focuses on integrated models of holistic, trauma-informed care, providing a foundation for the review of the True Support Services Hub (TSSH) pilot.

Coordinated community responses to sexual violence

Coordinated community responses to sexual violence are not new. A variety of interventions and support models exist to aid victim-survivors of sexual violence. These range from services that provide legal and medical assistance to community-based clinics that offer psychological support. Coordinated community responses have been adopted in the domestic and family violence sector: while not responding specifically to sexual assault, the two are frequently inextricably linked. Interventions targeted at the immediate aftermath of a sexual violence event are referred to as crisis response models and are differentiated from post-crisis models that address the long-term efforts of recovery. The best described crisis response models feature sexual assault response teams (SARTs) and sexual assault nurse examiner (SANEs) programs (Greeson & Campbell, 2014; Adams & Hulton, 2016).

Many of these services utilise public hospitals and local health clinics to provide medical attention and may direct victim-survivors to counselling and police services (sometimes off-site) via a shared network or interagency service provision (Temmerman et al, 2019). Although the operation of this model is interconnected, the victim-survivor may still need to travel to an external location to access these resources and may be engaged by multiple new

support staff, having to recount the sexual assault on multiple occasions, increasing the risk of re-traumatisation (Coates et al., 2022).

The concept of a centralised hub where all support resources are situated under "one roof" is not novel: many SARTs already operate in this way. Greeson & Campell, (2012) published one of the first and only empirical reviews on the effectiveness and challenges of successful SART implementation and identified organisational barriers, lack of therapeutic alignment, conflicting goals and role confusion as limitations and areas for further research. Many of the community models that are established to address sexual violence were done so pragmatically and often not afforded academic, theoretical consideration or evaluation. Little of the peer-reviewed literature speaks to the operational and logistical factors to consider when implementing a coordinated response to sexual violence; much of the field has focused on advancements in providing trauma-informed care, enhancing trust, the quality of relationships and the psychosocial and emotional response by victim-survivors to trauma and recovery (Coates et al, 2022). The operational and systems infrastructure remains to be explored in the literature. However, partner agencies in multidisciplinary centres in Victoria, for example, are governed by an agreed *MDC Framework,* incorporating a Letter of Understanding, a Statewide Agreement, and a Local Agreement (Families, Fairness and Housing, 2020). The Letter of agreement sets out each partner's roles and responsibilities, including information sharing obligations; the MDC governance arrangements; and procedures for conflict resolution. The aim of the Statewide Agreement is consistency across Victoria in quality client centric service from one location, and the Local Agreement is to support operational arrangements specific to a location (Families, Fairness and Housing, 2020). Nevertheless, there is scant assessment of the effectiveness of these models in the published literature, and the grey literature appears to be limited to descriptions of the interagency models and the services they offer.

The "wrap-around" response model

Access to immediate and streamlined medical and psychological care is crucial for addressing physical injuries and preventing re-traumatisation in the acute phase after sexual assault. The "wrap-around" model of response, also known as the "one stop centre" (OSC) model is an integrated approach beyond a coordinated community response that aims to holistically address the complex medical and psychosocial needs of each victim survivor. There are many overlaps with multidisciplinary coordinated SARTs where various services are integrated at the one site to provide comprehensive care and assist with reporting (Barbara et al, 2019; Olson et al, 2020). Access to these multidisciplinary

services from a single point may significantly improve outcomes for sexual violence victim-survivors by addressing multiple aspects of a victim survivor's well-being. This approach is understood to reduce the risk of re-traumatisation and promote long-term recovery which is evidenced by experts and professionals in the field, though again, formal academic evidence of this is limited.

Upon a comprehensive literature search of PubMed, Google Scholar and Australia's National Research Organisation for Women's Safety (ANROWS), there is little peer-reviewed information or singular definition of a "wrap-around" model or OSC, especially how they would be differentiated from SART models currently in practice. Much like coordinated community responses, there are few academic publications that describe the establishment and set up of a wrap-around model from idea conception to practical delivery.

Some studies have explored interprofessional collaboration and organisational alignment within a multidisciplinary SART model (Moyal et al, 2015; Cole, 2018); however, their findings focused more on the relationships between stakeholders and conflict resolution than establishing a best practice model or implementation framework. As such, many organisations, experts and professionals in this field may already be implementing these models in their service offerings where much of this information is documented extensively in the grey literature but not in an academic, peer-reviewed journals available through library databases.

Lack of funding and limited resourcing for evaluations may contribute to the limited journal articles on this topic. Like many other areas of high unmet need, the opportunity to conduct rigorous academic research is often a luxury that is difficult to actualise given the priority of acute and ongoing victim-survivor care.

Methods

The successful grant application proposed that an evaluation of the pilot would draw on police and hospital administrative data and interviews with two groups of participants: 1) an estimated 50 victim-survivors who attended the TSSH, and 2) up to 10 relevant service providers within True and allied services (the Queensland Police Service and Queensland Health).

The Griffith University Human Research Ethics Committee granted ethics clearance (2023/716) in September 2023. The TSSH, operating from 8am to 4 pm from Monday to Friday, commenced in early January 2024, following recruitment of staff and formal agreements with allied services—Central Queensland Hospital and Health Services and the Queensland Police Service.

By April 2024, however, only two women had been able to access TSSH for support[8] after sexual assault and it became apparent that the proposed sample of 50 victim-survivors who attended the TSSH would not be achieved. More importantly, the True CEO was concerned that victim-survivors needing the services of the TSSH were not getting that service. The CEO commissioned an interim review of the TSSH to assess the efficacy of the model, to date, and consider modifications based on key learnings.

Interim review

The interim review (Nancarrow, 2024, unpublished) found that True had successfully established the TSSH The interim review report recommended two key modifications: 1) that the TSSH 3-day per week counselling position be terminated and replaced with a counselling service delivered by the Women's Health and Information Referral Service Central Queensland (WHIRSCQ)on a fee-for-service basis; and 2) that the pilot be made available 24 hours, seven days a week. Soon after the report was delivered, the counselling position was declared redundant and True has entered into a service agreement with WHIRSCQ to deliver the pilot's counselling component. Due to resource constraints, True has not been able to expand the pilot's hours of operation. Further details of the interim review process and outcomes is provided in Appendix 2. Relevant information from the interim review, such as the background to the pilot program, the statistical profile of sexual assault in Australia, and the unofficial QPS data for sexual assaults in the region, is incorporated in this final review report.

Data collection

The Measure of Victim Empowerment Related to Safety (MOVERS) Scale was to be adapted and applied in an evaluation of the TSSH model as the primary data collection tool. However, the small number of victim-survivors attending the TSSH in the pilot phase and the consequent modification to the counselling component, resulted in modifications to the data collection methods.

On advice from WHIRSCQ, it was agreed that clients of their service would be invited to participate in an interview, reflecting on their own initial help-seeking

[8] Another two had presented to the police and referred to the TSSH, but were unable to be provided the service due to insufficient staff availability: that is, the pilot was unable to fund a sufficient number of forensic nurse examiners to cover even the regular business hours of operation.

experience and how that experience may have differed had the TSSH model been available to them. Variations to the research protocol were approved by the Griffith University Human Research Ethics Committee (HREC) prior to the commencement of data collection.

Sample

The sample comprised two participant groups: 1) people with lived experience of sexual assault and the mainstream system that responds to sexual assault; and 2) service providers associated with the TSSH pilot.

Participant group 1

On behalf of True, WHIRSCQ distributed a text message invitation to approximately 60 of their clients inviting their participation in the evaluation of TSSH.[9] The invitation was sent to clients that WHIRSCQ counsellors believed had sufficiently recovered from the trauma of sexual assault and that the risk associated with participation would be minimal. The invitation briefly explained the model and that they would be asked to reflect on how useful it would have been for them when they first sought support related to sexual assault. Prospective participants were also advised they would be compensated with a $50 gift card.

Three women with lived experience agreed to participate via a telephone interview. They were provided with information about the project and the consent process, with formal consent to participate given before the telephone interview commenced. The information and consent forms used, and the set of questions that guided the interviews, are included in Appendix 3.

Participant group 2

Invitations to participate in the TSSH evaluation were sent to relevant members of the Queensland Police Service (QPS), and staff of Queensland Health and True. Three members of QPS indicated their willingness to participate, as did one representative of the Central Queensland Hospital and Health Service and a senior True staff member, whose responsibilities include management of staff associated with the TSSH.

[9] The 60 clients were simultaneously invited to participate in the annual service quality assurance audit conducted by WHIRSCQ as required by its funding agreement with the Queensland Government. This dual invitation was designed to reduce intrusion on clients' time but is likely to have resulted in many clients choosing to participate in the WHIRSCQ audit, only.

Due to work demands and scheduling conflicts, only two QPS representative were able to participate in the review process. As with Group 1 participants, the participants in Group 2 were provided with information about the project and the consent process, with formal consent to participate given, before the interview commenced. The information and consent forms, and the set of questions used to guide the semi-structured interviews for this participant group are also included in Appendix 3.[10]

Data management and analysis

The interviews were audio-recorded and transcribed, with the transcriptions stored on a password protected computer, accessible by the lead researchers, only. No identifying information was collected or recorded. A data file was created for each participant and coded VS1 through VS3 for the three victim-survivors who participated, and SP1 through SP4 for the four participants who were involved in delivering the TSSH.

The data were then subjected to an inductive thematic content analysis. This process allows themes to emerge from the data, rather than starting with preconceived themes based on a theory to be tested. It involves identifying consistent themes across the data from both participant groups, and any discrepancies between the two groups. The latter is especially important in enabling the perspectives of people with lived experience to inform the evaluation and its consequences for future service development.

Where appropriate and useful, quotes are included in the results to illustrate themes emerging from the data. The quotes are attributed to the respective participants by using the code assigned to them, as discussed above.

Limitations

The small sample size in both participant groups is a significant limitation in analysing the efficacy of the TSSH model. Indeed, the proposed evaluation of the model could not proceed as intended due to the small number of victim-survivors attending the TSSH during the 1-year pilot. After 3 months of operation and only two victim-survivors having been provided the services of the TSSH,[11] an interim review of the TSSH (Nancarrow, 2004, unpublished) was commissioned by

[10] Most questions were relevant to both the interim and the final reviews and all were consistent with the research protocol approved by the Griffith University HREC in September 2023.

[11] At the commencement of data collection for the final review, a total of 10 victim-survivors had been referred to TSSH.

True. The purpose of the interim review was to determine if any modifications were needed to support the successful implementation of the model. This report draws on the results of the interim review, as well as the data subsequently collected.

Further, the service providers recruited to participate in both reviews (QPS, Queensland Health and True Relationships and Reproductive Health staff), were all directly involved in the establishment and delivery of the TSSH. Therefore, the work presented here is more appropriately considered a final review of the TSSH pilot.

These limitations should be seen, at least in part, as a consequence of the pilot funding, time-frame and location. This point is expanded on in the discussion that follows the final review results.

Results

Three major themes and six sub-themes emerged from the data. These are discussed below, with indicative quotes from participants—service providers (SP) and victim-survivors (VS).

Timeliness

This theme had two dimensions: one referring to the model's positive impact on a timely response to victim-survivors of sexual assault, the other being a negative consequence of the model's hours of operation.

Timeliness of TSSH response

The positive impact is the relative immediacy of the forensic examination, compared to the hospital setting, following presentation at the TSSH. Service providers unanimously identified the timeliness of the response to victim-survivors as a major strength of the model.

> "Their needs are prioritised compared to hospitals where people needing life-saving medical intervention have to be prioritised" (SP2).

> "TSSH was an opportunity to reduce the barrier of having to go to A& E and experience a long and emotionally uncomfortable wait for forensic examination. At TSSH they're … brought through to a soft, emotionally safe private room and seen straight away – they felt they were progressing at all times – which they were …" (SP1).

Restricted hours of access to TSSH

The negative relates to the restricted hours of operation (8am – 4pm, Monday to Friday). All service providers asserted that access to the TSSH during regular business hours only was a substantial deficit in the model, restricting immediate access for victim-survivors in the aftermath of a sexual assault. This means, for many victim-survivors, that they will not have access to a timely response and will need to present to the hospital accident and emergency department (A&E) for a forensic examination, if evidence is to be collected and stored in the aftermath of the assault:

> "Because the TSSH is so timely, patients never walked out before the process was concluded – that happens all the time at the hospital because it takes too long" (SP1).

The restricted hours of operation were the only negative aspect of the pilot model identified by participants, although a number of challenges associated with addressing this deficit were identified. These are addressed in the discussion that follows the results of analysis.

Trauma-informed response

Timeliness and a trauma-informed response to victim-survivors are inextricably linked. Timeliness alone, however, is not sufficient to provide a trauma-informed response in the aftermath of sexual assault. All participants commented on the value of a trauma-informed place, collectively mentioning the following features: a private, emotionally safe and comfortable place for victim-survivors to sit, talk and be believed and supported by the relevant professionals in one place, without having to repeat their story each time they engaged with a different component of the system.

A safe, holistic, one-stop response

As one victim-survivor said (on reflecting how helpful the TSSH would have been at the time she needed support related to a sexual assault):

> *It would have been very useful to be able to go to just one place. I had to go to police and then they took me up to the hospital and the police took me back down to the police station and I had to go through all that. It was just two days after it happened so I was still really[pause]… yeah. They gave me all the information about other services and they contacted them to contact me, so I then had all these people contacting me – if I could have just gone to one place* …(VS1).

Another concurred on the value of the relevant support people being in the same place and expanded on the benefits of TSSH compared to reporting the police station:

> *The TSSH model would be way better. You'd have more people understanding. We had to go to the police station—there was no examination and it was like, "oh, you 're at the police station" and that makes you nervous and "oh shit dad's there, and "oh shit, mum's there and now everybody knows", and mum was blaming us and yeah—it wasn't good. Like [having] somebody in a nicer setting, making you feel comfortable and not like it's your fault would be better (VS2)*

Hospital avoidance

Participants drew attention to the inadequacy of the hospital as an effective response to sexual assault. Some emphasised that this is not intended as a criticism of the hospital or its staff but recognises that the primary role of the hospital's A&E department is to deal with medical emergencies, including life-saving interventions, that necessarily take precedence over forensic examinations. This typically results in extended delays and interruptions.

> *TSSH was an opportunity to [avoid] going to A&E and experiencing a long and emotionally uncomfortable wait for forensic examination* (SP1).

Hospital avoidance was also seen by another participant as important in providing support and enabling genuine victim-survivor choice about action to be taken in response to a sexual assault, because their needs can be prioritised:

> *Often times, the rooms for examination aren't available because life-saving medical procedures must take precedence. Further, when a person who has reported a rape is waiting at A&E with two detectives (even in plain clothes) there are eyeballs on them … It's not uncommon for victim-survivors to leave after 20 minutes or two hours of waiting [for the forensic examination]—it's too stressful and they say, "look I'm not doing this – I can't go ahead with it" and they just leave (SP2).*
>
> *From my perspective the hub has been extremely beneficial. We don't have to go through the madness of the emergency department at the hospital – it is one of the busiest places that I have ever been … and the amount of noise and people moving around. If we're taking a victim-survivor of sexual violence into that environment we're just running into so many barriers that prevent us getting the evidence that we need* (SP4).

Reduced barriers to formal reporting of sexual assault

Related to hospital avoidance and the provision of a trauma-informed response, service provider participants identified that victim-survivors were more likely to engage with police in making a formal complaint if they were able to access the TSSH. This is not an objective of the TSSH, which emphasises victim-survivor empowerment and choice. Nevertheless, genuine choice regarding a formal complaint is stifled by interventions that add to, rather than reduce, trauma. Service provider participants noted the following:

> *…when the TSSH option is explained the …victim-survivor seems more willing to engage with an investigation. We have so many reports to police that don't go anywhere because the victims don't want to engage [but] TSSH removes a barrier to engaging … (SP2).*

> *If people have appropriate care at the time of the assault and follow-up care then they are more likely to proceed to a forensic examination but if there's a delay with people getting to health care professionals, they may be less likely to proceed. Giving immediate support and the opportunity for a forensic examination without delay could lead to charges (SP3).*

Continuity of care

The benefits of a trauma-informed victim-survivor experience extended beyond the immediate response to sexual assault, as illustrated by the following observation:

> *… [there is also the opportunity at TSSH] to build rapport and a trusting relationship with the victim-survivor … encourages them to connect with True Clinic at a later date on other issues like contraception, or to get help with self-harm … So important to … have the time to engage … specialist Sexual Assault Nurse Examiners and Forensic Nurse Examiners can do all the necessary interventions … debunk myths, do the forensic examination, insert an IUD, for example* (SP1).

Diverse strategies to promote the TSSH

Victim-survivors typically accessed the TSSH via a referral from QPS, the hospital or child safety services: that is, agencies within the TSSH network, rather than self-referrals or referrals from general community-based organisations. All victim-survivor participants said better promotion of the TSSH was needed. The strategies that they suggested tended to focus on communicating directly to the general community, through social media, pamphlets in doctors' surgeries and notices in shopping centres and places such as Centrelink, Lifeline and St

Vincent de Paul. Promotion strategies suggested by victim-survivors indicate that they saw self-referral to the TSSH as an important, desirable pathway to its services.

One service provider commented on the need to better promote the TSSH, suggesting that mainstream media could be drawn into news stories about the TSSH if, for example, senior officials from police and Queensland Health were to visit Rockhampton, issue media releases, and make relevant announcements. Annual campaigns such as Domestic and Family Violence Prevention Month in May, and Sexual Assault Awareness Month in October offer valuable opportunities for significant events and announcements garnering mainstream media coverage.

Discussion

Over the course of this project, the TSSH has undergone an interim review in April/May 2024 resulting in a significant modification to the model. That is, due to the insufficient budget of $150,000 and the small number of clients (four) referred in the first three months of operation, the in-house, three-day per week, counselling/support position was declared redundant and outsourced under a formal agreement with the Women's Health and Referral Service Central Queensland (WHIRSCQ). In retrospect, this arrangement is likely to have been made at the outset, if there had been a funded, co-design process to support the development of the pilot model before commencement.

In 2024, the Department of Justice and Attorney-General (DJAG) funded such a process for three projects under the DJAG initiative *Diverse Cohorts - People Using Domestic and Family Violence Trial*. These projects received DJAG funding, to consult within the local community, and with the intended service users, to co-design the model through the development of three artefacts: 1) a theory of change and program logic; 2) program and staffing models; and 3) an outcomes framework. This co-design process was the first of three phases in the development and implementation of programs for diverse cohorts of people using violence. It was followed by the development of program resources and staff recruitment and then implementation of a 2-year pilot program to be evaluated using the outcomes framework developed in the co-design phase.

This approach is good practice: it represents a rigorous approach to project design and evaluation; it enables early engagement of key stakeholders in the local community, supporting collaboration; and it promotes awareness within the local, thus increases the likelihood of early referrals and maximises the opportunity for success in the program implementation. It is not known why this

approach was not taken with the Keeping Women Safe from Violence program, although it predated the program for *Diverse Cohorts - People Using Domestic and Family Violence Trial* projects by at least one year.

Another key recommendation from the interim review was extending the hours of TSSH operation through an on-call roster system. This recommendation could not be implemented due to the lack of resources: primarily insufficient funding and insufficient qualified Sexual Assault Nurse Examiners (SANEs), Forensic Nurse Examiners, and counsellors. Even if there were sufficient qualified personnel available to cover a 24-hour, 7-day per week roster, extended hours for TSSH would increase insurance costs and require engagement of after-hours security.

At the time of data collection for this final review in October and November 2024, a total of 10 clients had been referred to the TSSH.[12] This apparently small number of clients must be seen in light of the evidence on formal disclosures of sexual assault compared to the prevalence of sexual assault: less than 10 percent of sexual assaults are reported (ABS, 2023). This also applies to the analysis of unofficial police data provided for the interim review (Appendix 1). It shows that over the course of 10 years, a total of 639 sexual assaults were reported to Rockhampton police. Notably, 45 percent (288) of those were reported within 7 days of the assault and would have therefore been eligible for the TSSH acute sexual assault wrap-around service response.

The unofficial QPS data also show that the majority (n=175, 60%)of the reports occurred outside the TSSH hours of operation (8am – 4pm Monday to Friday). The need to extend the hours of operation, preferably enabling access 24 hours a day, 7 days per week, was a key fining of the interim review and has been reinforced by participants in the final review. While there are Sexual Assault Response Teams (SARTs) offering such after-hours access in a number of Queensland sites (e.g. Townsville, Cairns, and Brisbane) through an on-call roster for counsellors, they do not offer a wrap-around response in a community setting. Therefore, there is no after-hours sexual assault response in Queensland that avoids the added trauma of attendance at the hospital A&E, and in some cases the police station, discussed by review participants.

[12] As noted in the methods section of this report, the decision had been made following the interim review to invite clients of WHIRSCQ who were well into the recovery phase, to participate in the review, instead of TSSH clients.

The Victorian MDCs in Victoria offer 24-hour access to support but it appears that is through a 24-hour Sexual Assault Crisis Line. After-hours access (7.30am – 11.30pm, 7 days a week) is available to victim-survivors in Queensland through the Queensland Sexual Assault Helpline.

The TSSH and the Victorian MDCs differ in notable ways, although they both offer a trauma-informed, client centric multi-agency response. The MDCs values include supporting choice and self-determination (empowerment), although it appears that statutory intervention, including formal reporting of sexual assault to police, is emphasised. MDCs include "a specialised investigative team of detectives trained to provide a victim focused specialist investigative response to the complex crimes of sexual assault and child abuse" (Families, Fairness and Housing, 2020). Indeed, the Gippsland MDC website states:

> *Believe it or not, this is a special type of police station. It is one of eight Multidisciplinary Centres (or MDCs) around Victoria which are designed to provide an integrated and victim-centred way of responding to sexual crime and child physical abuse.*
>
> *MDCs, like this one in Morwell, house a range of agencies and services under the one roof, including the Victoria Police Sexual Offences and Child Abuse Investigation Team (SOCIT). Our specialist SOCIT teams work alongside empathetic and professional counsellors and advocates, DHHS, child protection staff, community health nurses and forensic medical officers."*

The SOCIT (Sexual Offences and Child Abuse Investigation Team) is co-located with the community nurses and counsellors in the MDC. On the other hand, TSSH emphasises clinical forensic nurse examination and counselling services in a community setting, and victim-survivor choice over engagement with police (and choice in general). The TSSH forensic nurse examiners are engaged by True Relationships and Reproductive Health at the TSSH. Police (Criminal Investigation Bureau—CIB) are able to bring victim-survivors to the TSSH and be available on-site to take a statement in collaboration with the clinic and counselling staff—thus avoiding the hospital and the police station.

Although increasing formal reports of sexual assault to police is not an objective of TSSH, feedback from the service providers indicates (and other evidence (e.g. Powell & Cauchi, 2009) demonstrates) that early and effective trauma-informed support for victim-survivors of sexual assault does result in increased reporting.[13] It could be argued then that models such as TSSH empower women to exercise their rights and make genuine choices about engaging the police, rather than

[13] They do not claim that Increased reporting results in increased prosecution and conviction for sexual assault.

simply avoiding a report due to fear that they will not be believed and or will be blamed for the assault, for example.

Further, McLindon et al (2024) found that recovery from sexual assault was aided by accountability for perpetrators and the broader community (in terms of acknowledgement of the harms and addressing victim-blaming). They also found that effective, integrated and early support and intervention for victim-survivors is important in the recovery process.

Based on the evidence above, TSSH undoubtedly has the potential to empower victim-survivors of sexual violence to exercise genuine choice and control over their stories, bodies and selves for recovery and healing (McLindon et al., 2024). Demonstrating this directly, however, is challenged by the insufficient resources allocated for the effective operation of the pilot (specifically the hours of operation), and the short amount of time (12-months) in which to establish, operate and evaluate the pilot.

During consultations for the interim review in April 2024, staff of WHIRSCQ discussed the time it takes for changes in service delivery to become known in the community services sector, citing continuing referrals they receive for domestic and family violence court support services, despite approximately four years having lapsed since that program had been transferred from WHIRSCQ to another agency. The lead time for effective service delivery is also the subject of a longitudinal study (Wathen et al., 2011). It found that translating evidence into practice requires extensive time to develop and execute effective communications and to build trust with stakeholders and intended program recipients. TSSH was afforded very little time and no communications budget for this purpose.

Nevertheless, the results of the interim and final reviews of TSSH have demonstrated that the model has significant merit and is highly valued by police and Central Queensland Hospital and Health Services. It eases the burden on their systems and provides better quality service for their clients.

Opportunities

The support of QH, the CQHHS and the QPS reflects the TSSH benefit for their sexual assault victim-survivor clients and the environment in which their work with sexual assault victim-survivors is potentially conducted (subject to accessibility, as needed). This level of support could be an opportunity to seek financial and in-kind contributions from the TSSH partners to address some of the identified challenges.

The following suggestions to capitalise on the support of the HHS and QPS, and meet the challenges associated with extended hours of operation, were proposed during the interim review process.

After hours security

Subject to negotiations with HHS, True could consider establishing an after-hours facility, such as an appropriately outfitted donga, in the hospital grounds. Under such an arrangement, the TSSH would utilise relevant hospital infrastructure, including security and reception/intake services.

This arrangement would also enable victim-survivors of sexual assault to be medically cleared by an emergency department doctor and immediately directed to the TSSH facility for SANE support and counselling (and, as relevant, to make a statement to police), while avoiding the trauma associated with hospital emergency department facilities.

Staffing

SANEs employed by QH could provide the forensic examination after hours in a TSSH facility, described above. This would ensure job security and maintenance of SANE skills, as well as after-hours access to qualified staff in a secure, trauma-informed environment.

Due to the challenges of ensuring the availability of a qualified forensic nurse examiner during current business hours, consideration could also be given to flexibility of QH-employed SANE's being on call to attend to TSSH clients during the current business hours, at the True clinic.

Concluding comments

Although numerous challenges for the TSSH were identified in both the interim and final reviews, there was strong overall support for the co-location, wrap-around model and enthusiasm expressed by all participants for it to succeed. This is consistent with developments in other jurisdictions, notably Victoria, which has been providing similar, community-based warp-around services for a considerable period of time.

In addition to the benefits of community-based forensic and police services for victim-survivors, described above, engagement with the TSSH also leads to continuity of care for related support services addressing, for example, contraception, sexual health and self-harm.

The interim review identified that modifications to the initial model were needed, particularly in relation to the provision of counselling and access to the service after hours.

The enthusiastic support of allied agencies may be harnessed to facilitate in-kind, as well direct funding contributions for the model. Further, given the current national focus on the prevalence and impacts of domestic, family and sexual violence, local corporations may be inclined to contribute to the TSSH with one-off philanthropic support, including costs of refurbishment to provide a more suitable sterile space for collection of forensic evidence at the True Clinic.

Recommendations

It is recommended that True Relationships and Reproductive Health:

1. Determine the cost of delivering the TSSH 24 hours, 7days per week, taking account of the one-off and recurrent costs referred to above, and drawing on a roster of on-call forensic nurses and counsellors.
2. Advocate that the Queensland Government provide the funding required to fully implement the model, enhancing the timeliness and quality of response to and support for victim-survivors of acute sexual assault in Queensland.

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Appendix 1: Time of QPS response to rape

10 Year Data (Rockhampton City Patrol Group – 0311 Rape)[14]

Days from day of occurrence to the day of reporting		
No. Days	***Occ Count***	***%***
0-7	288	45
8-30	33	5
31-90	50	8
91-365	62	10
>365	206	32
Total	***639***	***100***

Of the 288 reported within 7 days		
Day Reported	***Occ Count***	***%***
Mon	48	16.7
Tue	40	13.9
Wed	35	12.2
Thu	29	10.1
Fri	33	11.5
Sat	50	17.4
Sun	53	18.4
Grand Total	**288**	100

Broken down to time of day reported

Row Labels	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Grand Total
0000	3	2	3	2	2		1	13
0100	1		1	1	3	1	2	9
0200	2	1	1	1		3	4	12
0300	1	1	4	3		4	5	18
0400		2		1		2		5
0500						2	4	6
0600	1	1	3			1	2	8
0700			1			4	1	6
0800		1	1	2	1	1	1	7
0900	1	2	1		2	4	2	12
1000	3	3	1		1	1	2	11
1100	7	2		4		2	3	18
1200	2	4	1	1	1	3	1	13
1300	5		3		2	1	2	13
1400	1	3		2	2	3	3	14
1500	2		2		3	5	4	16
1600	1	1		1	3	1	2	9
1700	3	4	6	1	2		1	17
1800	2	5	2	2	2	1	2	16
1900	2	3		1	3	1		10
2000	4	4	3	1	2	5	5	24
2100	4		2	2	3	3	4	18
2200	2	1		1			1	5
2300	1			3	1	2	1	8
Grand Total	***48***	***40***	***35***	***29***	***33***	***50***	***53***	***288***

[14] Disclaimer – these figures are not official Queensland Police Service statistics. See Footnote 9.

Appendix 2: TSSH interim review summary

Process

Consultations were conducted with key staff, and allied agencies: specifically, the Queensland Police Service and the Women's Health, Information and Referral Service Central Queensland Inc (WHIRSCQ). The following set of questions served as a guide for the consultations:

1. Coud you please tell me from your perspective what the objectives of the TSSH model are?
2. Based on your experience with TSSH over the past 3 months, what has worked well?
3. It's not uncommon for new service models to face hurdles when they are finally up and running. What are the key challenges faced by TSSH?
4. What could be done to address those challenges?
5. Do you see any barriers to achieving the objectives of TSSH, and if so, how could they be addressed?
6. Should TSSH focus on delivering its services to women in Rockhampton, or should its services extend to other communities in the region? If "yes", please indicate how far the service should extend and why.
7. Is there anything else you'd like to add to assist the interim review of the TSSH model?

Individual meetings were held on 23 and 24 April 2024 with the following key personnel:

- Ms Lisa Harrison, Director of Nursing and Health Services, True (Statewide)
- Ms Rhonda Western, Sexual Assault Counsellor, True Support Services Hub
- Ms Rebecca Rendalls, Clinic Nurse Manager, True, Rockhampton
- Detective Sergeant Jason Milner, CIB, Rockhampton
- Ms Linda Kirby, Nurse Practitioner, True, Rockhampton.

A group meeting was held on 23 April 2024 with Ms Janis Littleboy, Manager, WHIRSCQ and two WHIRSCQ Team Leaders: 1.Counselling and 2. Business.

The duration of each meeting varied between 30 and 55 minutes. The discussions were audio-recorded, transcribed, and subjected to an inductive thematic content analysis to inform the review report.

Outcomes

The interim review found that True had successfully established the TSSH as a safe, trauma-informed community-based environment for victim-survivors of sexual assault,

supported by the Queensland Police Service (QPS), the regional Hospital and Health Service (HHS), and other external agencies.

However, very few victim-survivors accessing the TSSH, and the capacity of the pre-existing WHIRSCQ, rendered the in-house counselling component redundant. A key limitation of the model is its hours of operation—8 am to 4 pm, Monday to Friday. Unofficial QPS data provided for the review indicated the need for the service to be available on demand, 24 hours a day, seven days a week; albeit client numbers would remain relatively small.

A range of other issues associated with expanded hours of operation emerged: security, insurance, and staffing. Each of these has significant recurrent cost implications: therefore, the limited hours of operation of the pilot TSSH remain the same. Finally, the review identified the need for some adjustments to the physical space to ensure optimum utility for the TSSH services.

Appendix 3: Data collection process

PARTICIPANT GROUP 1: VICTIM-SURVIVORS OF SEXUAL ASSAULT

True Support Services Hub (TSSH) Research: GU Ref No 2023/716

CLIENT INFORMATION SHEET

Who is conducting the research?

Name: **Dr Heather Nancarrow AM**
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Name: **Dr Karen Struthers**
CEO and Research Coordinator, True
Phone: 07 38261500
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Why is the research being conducted?

The research is primarily funded by the Department of Justice and Attorney-General (DJAG). The purpose is to examine the impact and effectiveness of the pilot True Support Services Hub (TSSH) - a sexual assault colocation with the True sexual and reproductive health clinic Rockhampton.

What you will be asked to do

You will be asked to participate in individual interviews. You may choose to be interviewed face-to face or by telephone. In the interview you will be asked for your views on the service you received at True. The interview will take about 20 minutes. It may be audio-recorded so that the researchers can be sure they have captured everything you say. The recording will be converted to a word document. No identifying information will be included on the document so the information cannot be attributed to you.

The basis by which participants will be invited to participate

A selection of victim-survivors (50 maximum) aged 17 years and older, and stakeholders/ service providers (10) will be invited to be interviewed. Members of stakeholder organisations, such as Rockhampton Hospital staff, will receive a written invitation to participate in an interview. Invitations will be sent to approximately 10 stakeholders.

The expected benefits of the research

The research will assess the impact and effectiveness of the True Support Services Hub. An expected benefit of the research is that knowledge will be acquired on the benefits and/or limitations of the community-based forensic and psycho-social support offered at the TSSH model. This knowledge will be used to improve the effectiveness of True services to victims/survivors of sexual abuse, and to encourage similar models being applied in other regions of Queensland.

Risks to you
Sexual violence is a traumatic event and there is a risk that you may experience some emotional distress when discussing the impact of the support you received from True. No other risks are anticipated. If you do experience distress, you may wish to call an external specialist support service such as 1800 RESPECT (1800 737 732) or DVConnect (1800 811 811). You are welcome to withdraw from the interview at any time. You are also welcome to have a support person attend the interview with you. With your consent, a True clinician will contact you in 1-4 weeks for a follow up mental health checkup.

Privacy Statement
The conduct of this research involves the collection, access, storage and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes, including publishing openly (e.g. in an open access repository). However, your anonymity will at all times be safeguarded.
For further information consult the University's Privacy Plan at https://www.griffith.edu.au/about-griffith/corporate-governance/plans-publications/griffith-university-privacy-plan.

Your participation is voluntary
Your participation is voluntary, and you are free to withdraw from the interview or research process at any time. You will not be judged, penalised or disadvantaged in any way if you do withdraw. It would be very helpful and much appreciated if you could inform the researchers if you do decide to withdraw from participation in the research.

Further information
If you would like additional information or you have concerns about the project please contact Karen Struthers (contact details above).

Ethical conduct of this research
Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research*. As a research partner with Griffith University True also adheres to these standards. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 3735 4375 or research-ethics@griffith.edu.au.

Feedback to you
copy of the report and a summary can be provided to you by email, if you wish. A report will also be provided to the funding body, the Queensland Government Department of Justice and Attorney-General.

Thank you for your interest in this research.

Research Team

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Dr Karen Struthers
Research Coordinator, True
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Email: karen.struthers@true.org.au

True Support Services Hub (TSSH) Research: GU Ref No. 2023/716

CLIENT CONSENT FORM

I confirm that I have read and/or had the nature and potential risks of the research explained to me and I understood the information. In particular:

- I understand that my involvement in this research will include participation in an individual phone or face to face interview, which may be audio-recorded;
- I have had any questions answered to my satisfaction;
- I understand the minimal risks involved in my participation, that I may have a support person attend an interview with me, and that I may contact DVConnect (1800 811 811), or 1800RESPECT (1800 737 732) if I wish to receive external support;
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary;
- I understand that if I have any additional questions, I can contact the research team;
- I understand that I am free to withdraw at any time, without explanation or penalty;
- I accept that data will be deidentified. I consent to use of identified data only where this is specifically agreed in writing by me;
- I understand that I may check the transcript of my interview if I wish;
- I understand that data collected for this research will be kept for 5 years and may be used in future research with similar aims;
- I consent to the use of identified data only where this is specifically agreed in writing by me;
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 4375 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project; and
- I agree to participate in the project.

Name: **Interviewer signature:** **Date:**

I would like to:

a) check the transcript of my interview: **Yes/No**. b) receive a copy of the research report: **Yes/No**

If "Yes" is selected, please provide an email address: _____

I consent to being contacted in 1-4 weeks for a follow up mental health check: **Yes/No.**

Victim-survivor interview schedule

1. Thinking of a wrap-about model (True forensic nurse examiner, support from WHIRSCQ, and police response if the victim-survivors wishes to see police) of support services, how useful would that have been to you?

(Very useful) 1 2 3 4 5 (Not useful at all)

1a. Please explain your response in detail. E.g. why, why not?

2. What's the best way for True and WHIRSCQ to share this information for people to know about this service?

3. How did you first make contact with the counselling service you use currently?

4. What would enable victim-survivors to call for professional help and support immediately (or within a few days) after a sexual assault?

5. Do you have any other comments to make?

6. Would you like to add to, or change, anything you've said in response to the questions asked?

Thank you. Your input is very valuable and much appreciated!

PARTICIPANT GROUP 2: STAKEHOLDERS

True Support Services Hub Research: GU Ref No 2023/716

STAKEHOLDER INFORMATION SHEET

Who is conducting the research?

Name: **Dr Heather Nancarrow AM**
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Name: Dr Karen Struthers
CEO and Research Coordinator, True
Phone: 07 38261500
Email: karen.struthers@true.org.au

Why is the research being conducted?

The research is primarily funded by the Department of Justice and Attorney-General (DJAG). The purpose is to examine the impact and effectiveness of the pilot True Support Services Hub (TSSH), an initiative led by True sexual and reproductive health clinic, Rockhampton.

TSSH is an innovative service response to acute sexual assault. It aims to provide immediate and coordinated:

- forensic nurse examination services (to collect evidence if the victim-survivor wants to press changes, or may wish to at a future date);
- police response (that may or may not include a formal statement to police); and
- information and support provided by the Women's Health and Information Referral Service in Central Queensland (WHIRSCQ).

What you will be asked to do

You will be asked to participate in an individual telephone interview. In the interview you will be asked for your views on the effect of the interagency collaboration provided by the True Support Service Hub for clients of your service. The interview will be around 20 minutes duration. It may be audio-recorded so that the researchers can be sure they have captured everything you say. The recording will be converted to a word document. No identifying information will be included on the document unless you specifically ask that your ideas be attributed to you. The audio-recording will be deleted as soon as it is converted to the word document.

The basis by which participants will be invited to participate
A selection of victim-survivors (n=25 max) and (n=10) stakeholders will be invited to be interviewed. Members of stakeholder organisations, such as Rockhampton Hospital staff, will receive a written invitation to participate in an interview. Invitations will be sent to approximately 10 stakeholders.

The expected benefits of the research
The research will assess the impact and effectiveness of the True Support Services Hub. An expected benefit of the research is that knowledge will be acquired on the benefits and/or limitations of the community-based forensic and psycho-social support offered at the TSSH model. This knowledge will be used to improve the effectiveness of True services to victims/survivors of sexual abuse, and to encourage similar models being applied in other regions of Queensland.

Risks to you
Some service providers are also victim-survivors of sexual assault and participation in the research may trigger painful memories. No other risks are anticipated. If you do experience distress, you may wish to call an external specialist support service such as 1800 RESPECT (1800 737 732) or DVConnect (1800 811 811). You are welcome to withdraw from the interview at any time.

Privacy Statement
The conduct of this research involves the collection, access, storage and/or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes, including publishing openly (e.g. in an open access repository). However, your anonymity will at all times be safeguarded. For further information consult the University's Privacy Plan at *https://www.griffith.edu.au/about-griffith/corporate-governance/plans-publications/griffith-university-privacy-plan.*

Your participation is voluntary
Your participation is voluntary and you are free to withdraw from the interview or research process at any time. You will not be judged, penalised or disadvantaged in anyway if you do withdraw. It would be very helpful and much appreciated if you could inform the researchers if you do decide to withdraw from participation in the research.

Further information
If you would like additional information or you have concerns about the project, please contact Karen Struthers.

Ethical conduct of this research

Griffith University conducts research in accordance with the *National Statement on Ethical Conduct in Human Research*. As a research partner with Griffith University True also adheres to these standards. If potential participants have any concerns or complaints about the ethical conduct of the research project they should contact the Manager, Research Ethics on 3735 4375 or **research-ethics@griffith.edu.au.**

Feedback to you

Findings and results of the research will be reported publicly and will be provided to you. A report will also be provided to the funding body: the Queensland Government Department of Justice and Attorney-General.

Thank you for your interest in this research.

Research Team

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True Support Services Hub (TSSH) Research: GU Ref No 2023/716

STAKEHOLDER CONSENT FORM

I confirm that I have read and understood the information package and in particular:

- I understand that my involvement in this research will include participation in an individual phone or face to face interview, which may be audio-recorded;
- I have had any questions answered to my satisfaction;
- I understand the minimal risks involved;
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary;
- I understand that if I have any additional questions I can contact the research team;
- I understand that I am free to withdraw at any time, without explanation or penalty;
- I accept that data will be deidentified. I consent to use of identified data only where this is specifically agreed in writing by me.

- I understand that I may check the transcript of my interview, if I wish.
- I understand that data collected for this research will be kept for 5 years and may be used in future research with similar aims.
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 4375 (or research-ethics@griffith.edu.au) if I have any concerns about the ethical conduct of the project;
- I understand that I will be provided access to the research results upon completion of the project; and
- I agree to participate in the project.

Name: **Interviewer signature:** **Date:**

I would like to:

a) check the transcript of my interview: **Yes/No**. b) receive a copy of the research report: **Yes/No**

If "Yes" is selected, please provide an email address:

Interview Schedule – Queensland Police, clinician and service provider

1. In what capacity did you work with the True Support Services Hub staff and clients (inc. QPS officers)?
2. What is your understanding of the role of True Support Services Hub?
3. Do you know that the TSSH is supporting victims/survivors of sexual assault and identifying and supporting clients experiencing reproductive control?
    a . Yes / No
4. Has your contact with TSSH improved your understanding of sexual assault and /or reproductive control? Please explain:
5. Do you feel confident in referring victims/survivors to the True Support Services Hub? Yes / No; Please explain:
6. What impact does joint work, through co-location of clinicians and counsellors have in:
    a. supporting the safety and wellbeing of victims/survivors;
    b. acquiring physical evidence of the offence;
    c. support victims/survivors to report offences and navigate the criminal justice system?
    d. reducing demand on Queensland Health services?
7. How do you think joint work between the clinic, counsellors, QPS can be improved?
8. Is it beneficial to continue True Support Services Hub beyond a pilot phase? Please explain.
9. Do you have any other comments to make?
10. Would you like to add to, or change, anything you've said in response to the questions asked?

Thank you. Your input is very much appreciated!