Mapping health sector and interagency protocols on sexual assault

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In response to broad enquiry from sexual assault services around Australia, this paper looks at the range of formal health sector protocols that currently exist to guide service responses to victim/survivors of sexual assault, throughout Australia’s different states and territories. The specific protocols reviewed here tend to be those that guide interaction between medical, counselling and police services who respond to sexual assault in terms of crisis care and, sometimes, beyond.

Protocols between agencies that provide services to victim/survivors of sexual assault have been developed only recently and largely independently of each other around Australia. National service associations and national conferences have resulted in substantial information sharing between state and territory agencies in the development of protocols and practices, but essentially each region has tended to develop separate frameworks. As each state and territory seeks to understand the effectiveness of their responses to sexual assault, there is reason to look across borders to see how others have evolved and how effectively they have been implemented on the ground. Questions about the current status of interagency working relationships, levels of training and approaches to evaluation also arise. More importantly, there is the question of whether the existing protocols adequately respond to the often complex health care and support needs of women, children and men who experience sexual assault.

This paper aims to provide a point of departure for agencies to begin to contemplate these issues. It will enable service providers and policy makers to consider the kinds of models or approaches that currently exist to meet the needs of victim/survivors, and the nature of, and/or responses to closing any gaps in service provision.

Two central questions form the lens through which these protocols are reviewed. First, what parallels and divergences exist between states and territories; and second, how well do the protocols sit within agency responses in view of the burgeoning understanding of the significant and
potentially chronic health impacts of sexual assault. In this context, the available information has been supplemented by speaking directly to a small number of service providers, particularly those working in regional areas, to explore whether the existing protocols have been relevant or easily adapted to localised areas. This direct communication with service providers certainly provided “flesh to the bones” of understanding how variously the protocols worked in practice, and the degree to which they could still operate effectively when challenged by the particular circumstances of local communities.

There are three main sections to this paper. The parameters of the review are outlined first before going on to examine the historical development of protocols designed to guide a medico or health-care response to sexual assault. The second section of the paper outlines some of the more significant conceptual and political influences on the development of existing protocols. The significance of the push by women’s services throughout the 1980s in Australia, to ensure that victim/survivor-informed perspectives were central to any systems’ reform particularly in terms of approaches to forensic care, or in improving the police response, is given particular emphasis.

A snapshot view of the protocols that currently exist in each state and territory is then provided. Two of these protocols – those in Melbourne (Victoria) and Townsville (Queensland) – are explored in detail to illustrate the different historical, political and regional contexts that inform the development, content and effectiveness of inter-agency protocols on service provision.

The last section discusses the efficacy of the protocols against a growing body of empirical research that reveals serious and long-term health impacts and consequences of sexual assault and other forms of gender-based violence. The future (re-)design of interagency sexual assault protocols will need to move “beyond crisis care” to more fully integrate the longer-term health needs of victims in the light of this knowledge.
Parameters of this review

A detailed national comparison of all of the protocols that exist to direct individual service responses to sexual assault is beyond the scope of this paper. Instead, we focus on the leading mechanisms used by individual states and territories to define the broad working relationships that currently exist between major hospitals, specialist sexual assault services, women’s specific health agencies and community and regional health services, police services, and other victim support services whose business it is to respond to sexual assault.

Most of the protocols attempt to balance the victim’s needs for counselling and advocacy support, with the requirements of forensic and/or medical care, and for victims to be informed about their options for accessing a legal response. This paper leans towards exploring how health care in particular is accommodated within the existing protocols.

This approach takes account of:

- the likelihood of health care responses being subjected to review as awareness of the often long-term health consequences of sexual assault increases;
- a shift in social policy away from specialist, gender-based service delivery to mainstream health and community based responses. This will challenge the achievements of feminist inspired approaches that have sought to position service delivery in the context of understanding sexual violence and its responses as highly gendered;
- how most protocols tend to prioritise the health needs of recent victims. This paper details the historical development of protocols and the emphasis given to implementing appropriate crisis care responses. Models both here and overseas are now seeking to look “beyond crisis care” in terms of delivering quality health services to survivors of sexual violence.

Most protocols aim to co-ordinate service responses that allow victims to have prompt access to counsellors, doctors, and to police should they decide to make a report following a sexual assault. However, the manner in which services are delivered within each state or territory in response to sexual assault “crisis calls” at an inter-agency level varies widely.

The protocols examined in this Issues Paper were selected for the attention they give to health care issues and the extent to which their coverage is intended to be state- or territory wide. How adaptable the protocols might be across communities within individual states and territories was also explored. In particular, to gauge how flexible and adaptable individual protocols might be for accommodating the localised needs, resources, cultural specificities and geographical distances that smaller or more isolated service areas often manage (Neame and Heenan 2004).

This examination is also focused on protocols developed to meet the needs of adult victim/survivors of both recent and past sexual assault. In some instances protocols extend to services that provide care to children who are sexually assaulted. In those instances the descriptions will include reference to how the protocols might also be activated to respond to reports or notifications of child
sexual assault. However protocols guiding service provision specifically for children are not included here.

In undertaking the background research for this paper, it was assumed that the protocols would be formalised, documented, easily accessible and, to a certain extent, standardised across jurisdictions or regions. While this was the case in the main, particularly for protocols encompassing the delivery of forensic services, it is also true that for some jurisdictions and regions the protocols are under-developed or are still in draft or preliminary stages. In these cases, the status of the protocols was unclear. Some had only partially been formalised, or the content was little-known, poorly understood or ignored within or across agencies and organisations. The documentation provided therefore ranged from ratified codes of practice, to partnership agreements, to a series of committee meeting minutes or even verbal discussions between agencies. Surprisingly, protocols are not always available to parties external to the partner organisations, and in a couple of instances were not able to be located by the organisations themselves. Not only does this variation reflect the level of status afforded to some of the protocols but has implications for the extent to which the protocols can be subjected to external review and evaluation.

Finally, while the focus of this paper is on protocols that respond to victims of sexual assault, consideration must be given to the particular context of family and domestic violence (FDV). While the specific issue of male partner rape has often been the subject of neglect by researchers (Heenan 2004), more recent studies have been able to attest to the prevalence with which women experience sexual assault at the hands of their violent partners (Coker et al. 1998; Hegarty and Bush 2002). Specialist services in both the domestic violence and rape crisis fields have only recently themselves started to negotiate closer working relationships, in recognition of the extent to which sexual violence features amongst the range of violent behaviours experienced by women (Heenan 2004). Consequently some of the protocols reviewed here consider how the protocols relate to both sexual assault and FDV sectors.

What is a protocol?

The term “protocol” is used here in its widest sense to mean a formal agreement between different parties. It might refer to guidelines, policies and procedures, or codes of practice that involve co-ordination of services, Memoranda of Understanding, Strategic Plans, Standards of Practice, Partnership Agreements, and other shared agreements that formalise relationships across services. It is often used in a generic sense to refer to the documentation that often accompanies forensic investigation kits for sexual offences.

The variety of documentation illustrates the wide range of collaborative relationships that exist across agencies, institutions, and jurisdictions. Some protocols are “in-house” – that is, they apply to services provided within an institution such as a hospital or a government health service area, and may refer to the relationships between professionals such as nurses, doctors, counsellors or social workers. Others may describe the relationship between parties – for instance, where a peak body that represents the interests of sexual assault services across the state might have entered into a state-based agreement with a government department, or where a regional health care provider has established a particular working relationship with their local police service that can better serve the needs of the community in that particular location. Other “inter-agency” approaches guide
the interaction between individual service providers. In regional and remote areas this can often mean an agreement between two individuals who may be the sole workers in an agency. Some protocols refer only to business-hours practice, some to after-hours, and some to 24-hour responses.

The delimitation of services under these protocols also varies. Some protocols relate to the provision of support through either medical or legal processes, and some combine both medical and legal. Others cover a broad spectrum of services from advocacy and support at reporting and forensic examination, through to longer-term health-care follow-up, and social reintegration. Protocols also delimit coordinated services to victim/survivors in various forms. These include rights advocacy (such as the right to be believed, or to make a report), support through processes (such as forensic processes or criminal injuries compensation claims), "case management" (coordinating responses by health and legal services), support to social networks (providing information and counselling to non-offending family and friends), and/or services to the community or to agency personnel in the form of training, debriefing opportunities (for other professionals working with victim/survivors), process clarification, obligation and responsibility clarification, enumeration and delineation.

The general rubric of “sexual assault protocols” covers three main types of response:

- **Acute or crisis response** – responding to recent sexual assault where the collection of forensic evidence is of primary concern;
- **Service coordination response** – where the coordination of (largely acute or crisis) counselling and advocacy support, medical care, police involvement (where appropriate) and maximising appropriate and non-aggravating service provision to victim/survivors is the primary concern of the protocol; and
- **Historical response** – where adults (including adolescents) report historical childhood sexual assault, or where an adult (or adolescent) reports sexual assault beyond the time in which a forensic examination is considered viable.

**Elements of health sector protocols**

In theory, there are a range of health care and medical responses available to victim/survivors of sexual assault. This section provides an overview of the specific categories of responses identified above. They are: acute care, forensic examinations and follow-up medical care, and longer-term health responses. It is important to note, however, that while the same terminology might be used within the various protocols, the application or scope of the response might vary quite widely in practice.

**Acute or crisis medical care**

Acute or crisis responses are understood here to include sexual assault that has occurred within a prescribed timeframe, usually where the collection of forensic evidence is viable. The variation in timeframes nominated in the protocols looked at in this paper is between 48 to 96 hours. Regardless of whether there are physical injuries, most sexual assault services would suggest that, “[s]exual assault should be seen as a legitimate emergency case and given highest priority after those with life threatening illness, even where there is no evidence of severe physical injury” (Lincoln no date).

Dr Maureen Phillips, the Coordinator of the Medical/Forensic Services at Perth SARC also spoke of responding to the acute care needs of victims in ways that prioritised their emotional wellbeing:
“In the acute setting of recent sexual assault, a balance must be reached between access to Emergency Department facilities and the need for privacy, an emotionally supportive environment and adequate time. Severe physical injury is uncommon following sexual assault and the medical concerns of the majority of people will be adequately managed without the requirement for hospital treatment. In a minority of cases, some of which will not be immediately apparent, hospital treatment is essential. Recent sexual assault should be seen as a legitimate emergency and given high priority irrespective of physical injury, but the setting in which the patient is seen should be specific to their individual requirements. At SARC in Perth, we have the option of referring to any Emergency Dept or directly to the SARC facilities dependent on the patients needs as determined by medical or nursing triage.”

From the perspective of a victim/survivor there is also the possibility that pregnancy and sexually transmitted infections (STIs) may represent issues requiring acute or crisis responses. Emergency contraception, if it is to be administered, must be provided within appropriate timelines to have the best chance of being effective. While pregnancy is not an issue for male, or pre-pubescent or post-menopausal female victim/survivors, the potential for STIs must be considered across all age categories. However some studies have revealed how these issues are sometimes overlooked when treating a sexual assault victim. In the United States, research showed that for 160 cases of sexual assault [presenting at] emergency department visits, none had received “the full regimen of [recommended] antibiotics for sexually transmitted infections (STIs). [Only] 21 per cent of those eligible received emergency contraception” (Rovi and Shimoni 2002). Protocols can certainly assist in standardising the various health checks that should and must take place following a sexual assault. While most Australian protocols include health-care check-lists, the question of whether pregnancy and STI concerns are always addressed, particularly beyond crisis care when the presence of STIs is more likely to become apparent in the weeks and months following the assault, still remains (Olle 2004).

Forensic examinations

Sexual assault is a crime. In order to successfully prosecute criminal activity under an adversarial system of criminal justice it is necessary to prove the guilt of the accused beyond reasonable doubt. Central to an accused’s defence in most sexual assault cases is whether the prosecution can prove that the woman-complainant was not consenting to the activity in question. It is here that the collection of evidence, usually from the victim’s body, can be critical for establishing an absence of consent or “free agreement”.2

Ideally, forensic medical examinations are undertaken by trained medical personnel who have a sound understanding of the specific issues impacting on sexual assault victims. They are experienced in following the standard medico-legal procedures and in ensuring that the associated formal documentation that accompanies these procedures can be legally defended should they be required to give evidence in court on behalf of the prosecution.

Forensic examinations in and of themselves have no direct therapeutic purpose. Establishing processes for obtaining informed consent from the victim have therefore been at the core of developing protocols that might help victims to understand what is involved, to ensure they are aware of the nature of any
agreement they may give, and to advise them of other health needs that may need to be addressed that fall beyond the scope of the forensic examination.

While restrictions limit the window of time through which useable forensic samples can be taken following an assault, in most states and territories it is possible for the samples to be collected and stored in a secure location while the victim/survivor decides whether to take legal action (see accompanying Table). The only exception here is Victoria. Having control over decision-making around whether to go ahead and report to police, and being able to make this decision outside the time of the immediate crisis, is said to be an important part of victims’ regaining a sense of control over their lives particularly given the sense of powerlessness they experience during and immediately following the actual assault itself. (Scott, Walker and Gilmore 1995; Olle, D’Arcy and Gridley 2004).

**Longer-term health issues**

“Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim’s faith in a natural or divine order and cast the victim into a state of existential crisis” (Judith Herman 1992: 51).

Up to this point, discussion has focused on relatively short-term health responses and requirements of forensic medical care; however, there is a burgeoning body of research that now testifies to the longer-term health consequences of sexual violence. According to Jean Edwards’ (1996: 1) understanding, the role of “specialised medical care as an integral part of the therapeutic management of sexual assault is a relatively recent concept”. In the absence of this new social and policy landscape, women, and especially adult survivors, had largely been bearing the health effects of childhood sexual assault or historical sexual assault with no formal recognition of the extent to which their experiences were likely to substantially effect their health and wellbeing.

The health consequences generated by the trauma of sexual violence has the potential to endure well beyond the acute phase. These include both the physical, mental and emotional health of individuals as well as the social and economic health of entire communities. Physical health impacts documented by the World Health Organisation range from homicide through to increased vulnerability to disease (WHO 1997, v8).3 In terms of mental health outcomes, post-traumatic stress responses are particularly common (Scott et al. 1995: 53-71). Rates of traumatic and post-traumatic stress disorder and depression are greatly increased amongst women who have experienced violence as children, especially sexual abuse, and among women who have experienced violence including sexual violence in adult life (Finkelhor 1984; Brown and Adler 1991; American Medical Association on Scientific Affairs 1992; Bifulco, Saunders and Hamberger 1993 cited in WHO 1997, v8; Mullen et al. 1996). A wide range of post-traumatic stress responses carry the risk for many victim/survivors that the experience of surviving sexual assault will become embedded in normalised responses and manifest as significant and enduring mental health issues (WHO 1997, v4; D’Arcy 1999; Astbury 2001).

Health responses to sexual assault cannot necessarily be equated to medical responses in this context. Where a health response might include some medical aspects, a medical response has the potential to be counter-productive to health outcomes, as discussed below.
Historical development of health sector protocols

It is now beyond dispute that sexual violence can have devastating effects on the lives of women and children. However, historically, sexual violence has been treated as a relatively rare event, hardly warranting of any serious attention by policy makers, much less by health practitioners and health services. Women in particular were thought to experience only minimal harm from rape especially in cases where she knew the offender or was already sexually active.

Research undertaken in more recent times has challenged these misconceptions with findings clearly demonstrating that sexual assault has profoundly negative effects on victims’ physical, psychological and sexual health and, when left undressed, on the wider public health of communities (WHO 1997; Astbury 2001). It is only in very recent times in Australia, however, that sexual assault has been situated as an issue demanding a health response (Orr 1997). It was not until the early 1980s that the relationship between the health sector, specialist sexual assault services and legal services in Australia was first formalised (Carmody 1992; Orr 1997; Laing and Bobic 2002).

Largely, this was in response to victims describing their contact with police and the medical profession as highly distressing, and disproportionately focused on the requirements of investigations and the collection of forensic evidence, rather than on the emotional and physical well being of victims. Research further attested to the discriminatory attitudes held by members of the “helping professions” that coincided with widely held beliefs about deserving and undeserving victims.

Dr Jean Edwards, Medical Officer at the Royal North Shore Hospital Sexual Assault Service in Sydney, chronicles the pejorative attitudes that prevailed in forensic medical teaching texts as late as 1979 in Australia. Edwards cites comments from classic texts that made claims such as:

- “It will be found that in many cases where a charge of rape is made that the woman was really a consenting party, and that the charge was made in fear of a discovery of her lapse” (Smith and Fiddes 1955: 288);
- “No difficulty is experienced in singling out the chaste from the wanton” (Simpson 1975: 194);
- “Many allegations of rape are false, possibly as many as 11 out of 12. Such allegations may be from spite, jealousy, in order to precipitate marriage, etc.” (Gee 1979: 91);
- [in examining an accused] “If possible, take a history of the circumstances of the intercourse. The man’s story may accord better with the facts than the girl’s” (Gee: 94) (cited in Edwards 1996: 1-2).

Accordingly, forensic examiners and generalist health professionals responding to disclosures of sexual assault often delivered an inappropriate response, if indeed a response could be accessed at all (Carmody 1992: 14). Edwards notes that in New South Wales at least, no specialised training in sexual assault forensic assessments was available to doctors until 1988 (1995: 217). This meant that, for many victim/survivors, the services and processes intended to address the harms of sexual assault were often likely to have re-traumatised and silenced them. As research undertaken by Hardgrave, and then Bush, found during the 1970s: “Interventions [had] the potential to continue the victimisation of the woman or child who had been sexually assaulted” (Scott, Walker and Gilmore 1995: 27).
During this time, rape crisis services, many of them voluntary, laboured under the failure of police and hospital staff to recognise the importance of providing victims with access to immediate crisis counselling and support. Rape crisis counsellors were often not contacted until the victim had already undergone the forensic examination or until after they had commenced making their statement to police. In other instances, workers were not contacted at all and victims were kept unaware of the existence of services, or of their right to decide against making a formal report to police (Orr 1997: 58-59).

The determination of the women’s movement to advocate for systems change in the treatment of sexual assault led to greater public attention being given to the plight of rape victims (Carmody 1992; Orr 1997). Around the same time, empirical research began to expose the “science” of rape trauma. In 1974, Ann Wolbert Burgess and Lynda Holmstrom published their landmark research documenting their contact with more than 140 sexual assault victims as they worked to establish a model of crisis intervention through a nurse referral program at the Boston City Hospital (1974a, 1974b). Through establishing the Victim Counseling Program, Burgess and Holmstrom concentrated on developing a counselling approach that could reduce the potential for long-term physical and psychological effects of rape, while allowing the effects of rape to be more comprehensively understood and monitored. It was in this context that they coined the term “rape trauma syndrome” as a way of explaining how, for many women, the aftermath of rape was psychologically, emotionally and often physically debilitating (Burgess and Holmstrom 1974b). Their research ultimately provided the scientific foundation for establishing service approaches that prioritised more immediate and appropriate crisis intervention, that put victims’ physical and emotional wellbeing first.

Judith Herman’s work (1992) in recognising the degree of psychological trauma experienced by survivors of sexual assault precipitated moves to formally recognise the kind of “syndrome” of which Burgess and Holmstrom first spoke (1974a, 1974b). Post-traumatic stress disorder (PTSD) is now listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), published by the American Psychiatric Association (2000). This manual covers all mental health disorders for both adults and children and is the standard reference guide for psychiatrists in the United States and many other countries. While there is disagreement about the nature, accuracy and limitations of a clinical diagnosis such as PTSD in the context of understanding the impact of sexual assault, the formal recognition by the medical profession of a syndrome arising from trauma (where sexual assault is specifically nominated as a traumatic experience) was significant in locating the impact of sexual assault squarely within a health discourse.

As Herman (1992: 118-122) notes in her celebrated book, Trauma and Recovery:

“The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient’s present symptoms and the traumatic experience is frequently lost . . . Practically any name that gives recognition to the syndrome is better than no name at all.” (See also MacKinnon on the importance of naming the effects of rape, cited in Graycar and Morgan 1990: 273).
Sexual assault medical officer Dr Jean Edwards also pointed to the “substantial body of knowledge which recognises that dealing effectively with trauma as close as possible to its occurrence, and following up in the immediate period following the trauma is effective in helping to avoid the development of complex or prolonged PTSD symptoms” (1996 un-numbered pages: final page). The recognition that early intervention could mitigate the harms of sexual assault therefore became foundational to the manner in which feminist service frameworks for sexual assault evolved.7

In Australia, rape reform advocates applied the principles of crisis intervention theory in calling for service models that could allow 24-hour crisis care and support to be provided to recent victims. Handbooks and kits subsequently developed to guide service provision in the context of rape crisis work emphasised the importance of counsellors being equipped to co-ordinate the services of forensic examiners and police, while ensuring that as far as possible victims would be treated with sensitivity and respect, and would be able to make informed decisions about their legal, medical and counselling options (Gilmore and Evans 1980; Hewitt and Scott 1983).

By the early 1980s, state and territory governments, mostly through their respective health portfolios, had agreed to at least partially fund a number of specialist services for responding to sexual assault and family and domestic violence (Carmody 1992). Many of these developed from what had been self-run or volunteer groups that had previously existed without any formal government support (Orr 1997; Hunt 1998). Through the establishment of these specialist agencies, with their commitment to being informed by the neglected voices and experiences of victims themselves, grew a sound knowledge-base around what constituted good practice responses to sexual assault.

In 1990, the Centre Against Sexual Assault (CASA House) in Melbourne first published *Breaking the Silence: A Guide to Supporting Adult Victim/Survivors of Sexual Assault*, clearly promoting a model of service that enshrined a victims right’s-based approach (Scott, Walker and Gilmore 1995). Similar to Burgess and Holmstrom (1974a, 1974b), the authors sought to formulate an approach to service delivery that would, first and foremost, be grounded in practice and therefore remain accountable to women victims, both individually and collectively (Scott, Walker and Gilmore 1995: vii). It acknowledged the diverse needs of women making disclosures of both recent and past assaults, offered a framework for providing effective support to victims seeking crisis care or follow-up counselling support, and synthesised information that situated the treatment of rape within an historical, social, and political context. The Manual also resourced workers with very practical information about supporting women to access their medical and legal rights (Scott, Walker and Gilmore 1995: pp. 75 and 85).

This kind of methodical approach to outlining “the practice” of delivering good quality and consistent service responses was formalised in 1998 after the National Association of Services Against Sexual Violence (NASASV), with input from representatives from eighty services throughout Australia, published the *National Standards of Practice Manual For Services Against Sexual Violence* (Dean, Hardiman and Draper 1998). The Manual consolidated what constituted a professional and consistent service response to women, children and men who experienced sexual violence. Principles of access and equity, and a commitment to advocating a
victim’s rights approach, broadly defined the conceptual framework through which standards of excellence in direct service provision for sexual assault were to be measured. Most services against sexual assault now reference their practice against these national standards. These will be discussed in more detail in the next section of this paper.

While there are no guarantees that governments will continue to support specialist services as the primary point of intervention in response to both recent and past sexual assault, there undoubtedly now exists a public policy position that takes sexual violence, and violence against women and children in their homes, seriously. Most states and territories have policy documents or strategies that specifically point to violence against women as a key policy area for women’s health, women’s safety and for crime prevention. We now have the capacity to better estimate the size and scope of sexual violence through surveys that measure incidence and prevalence in local, national and global contexts (ABS 1996; Lievore 2003; Mouzos and Makkai 2004).

Much work has also been done to reform laws with a view to increasing the reporting rate of sexual assault and other crimes of sexual violence including violence perpetrated against women in their own homes by their partners or other family members. The rationale being that increased reporting will result in higher rates of convictions for sexual violence, that can act to prevent perpetrators from re-offending or to deter others from offending in the first place (Easteal 1992; VLRC 2003). For services, however, meeting the emotional support and health care needs of victims, especially in the immediate aftermath of an assault, has been a critical focus, regardless of the advent of police involvement.

Over the past two decades in Australia, the development of protocols guiding the inter-agency efforts of health (including forensic), counselling support and police services have attempted to cut across these kinds of competing interests. However, much of the focus has been contained to the period immediately following the initial presentation. Few of the protocols, at this stage, speak directly to the issue of managing longer-term health care needs of victim/survivors.

Reliably estimating the damaging health effects and enormous economic costs of sexual assault and domestic and family violence on the lives of individual victim/survivors, and on the broader community, have been relatively recent endeavours (Lee 2001; Laing and Bobic 2002; Krug et al. 2002; Access Economics 2004). However, landmark population-based research undertaken by the Victorian Health Promotion Foundation during 2004 unambiguously placed the impact of intimate partner violence as the leading risk factor to women’s health (VicHealth 2004). In fact, the study found intimate partner violence (including sexual violence) “is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other well-known risk factors, including high blood pressure, obesity and smoking” (VicHealth 2004: 8). The specific health outcomes that contributed to the “disease burden” of intimate partner violence on women included: problems with depression and anxiety, suicide, drug use and risky levels of smoking and alcohol consumption. Clearly this study has implications for how we, as researchers, as service providers, as policy officers, as governments, come to (re)view the points at which we can most effectively intervene, prevent, educate and raise awareness about violence against women.

In the following two sections, we will examine how inter-agency protocols currently harness the co-ordination of health, counselling and legal services in response to sexual assault.
Protocols and perspectives

This section explores some of the specific protocols that guide the medical response to sexual assault across the various states and territories in Australia. In the main, these protocols represent the formal working agreements developed between medical and health professionals, sexual assault services and police in coordinating appropriate responses to victim/survivors of recent sexual assault.

While the role of medical practitioners has traditionally been confined to forensic examinations that give emphasis to the collection of “physical” evidence that might assist with any court proceedings that follow from a police investigation, the specific mechanisms that drive the provision of forensic services vary across individual states and territories. For example, forensic examinations may be undertaken by doctors employed by sexual assault services, by police or more directly by the state government, they may be in general practice, or work in local health centres or hospitals; they may provide acute care in response to the immediate aftermath of a sexual assault only, or provide follow-up care throughout the months following the assault.

This section maps the details of individual protocols and specifically outlines: the parties to the protocol; when the document was first introduced; the circumstances under which the protocol should be activated (whether for adult and/or child victims, for recent and/or past assaults); any requirements for training by services who are the subject of the protocols; and the nature of the forensic or medical care provided.

The level of detail provided here tends to correspond with how well information about the history, development or establishment of protocols had, at the time of writing this paper, been archived or recorded. In some instances, anecdotal information was sought directly from services providers to supplement information about the protocols. In other contexts, ACSSA was able to obtain reports, publications, or rationale papers that helped to explain how the protocols came to life. Common to almost all states or territories, however, was how little was known about the operation of the various protocols. While some service providers emphasised the organic nature of the documents, or the extent to which the protocols tended to remain “dynamic”, few of the existing protocols had been subjected to more formal evaluation.

Greater attention is then given to the development of protocols in both Melbourne (Victoria) and Townsville (Queensland) largely because they are both well documented, but also because they represent, respectively, one of the earliest and one of the most recently developed protocols in this area.

While this paper focuses primarily on health responses to sexual assault, the role of police and the legal system is often particularised in the protocols given the potential impact that forensic evidence might have on the success or otherwise of criminal prosecutions. Research has continued to show how the presence of injuries or other forensic evidence can impact significantly on jury decision-making or in supporting victim-complainants’ accounts in court (Bargen and Fishwick 1995; Heenan and McKelvie 1996; Clarke 2002). To this end, many of the protocols attempt to balance the counselling, health care and support needs of victims with the requirements of police investigations.

However, for the purposes of this paper, only limited attention will be given to the police role or the legal aspects of individual protocols; the intention of this work...
is to scope, nationally, the range of current medical and health care responses being provided to victims of sexual assault. The focus on health responses also acknowledges the vast numbers of victims who ultimately decide against reporting to police, but who are nonetheless faced with imperatives around their medical and longer-term health needs. The immediate concerns that often follow a recent assault, such as the risk of pregnancy and sexually transmitted infection, possible injuries, and the levels of shock and distress, are a priority for many victims regardless of whether or not they opt to pursue a legal response.

The next section outlines some of the key influences on the development of inter-agency protocols: health policy, and in particular women’s health policy, guides the provision and operation of major health care service responses to victims of sexual assault; police services, in their role as gate-keepers to the criminal justice system, are also important players in the development of guidelines or protocols directing responses to sexual assault; and, importantly, the experiences and perspectives of victim/survivors, often related through service providers, have not only informed the development of coordinated service response models but provided a measure against which practice can, and ought, be critically assessed. The development of the national standards of practice has also set an important benchmark for the delivery of consistent, professional, and high quality service responses to victims of sexual violence. These will briefly be considered in turn before outlining the details of individual protocols in the next section.

The influence of health policy

Health policy development for women in Australia is mainly referenced against the principles of the National Women’s Health Policy (NWHP), established in 1985, which was said to have “signalled the beginning of joint State and Federal program funding initiatives” (Dean, Hardiman and Draper 1998). The goal of the NWHP was: “to improve the health and wellbeing of all women in Australia, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of women”. As one of its seven priority health issues, the policy nominates violence against women specifically:

“Violence against women – a need for preventative strategies was identified which addresses the conditions underlying women’s vulnerability to physical and sexual violence. Support services (including economic support) for survivors and their children and community education programs were highlighted as important requirements in this area.”

(Commonwealth Department of Community Services and Health 1989)

State health departments reference the NWHP as an important guide for the development of local policy. For example, New South Wales Health (2002: 4, 14-15) draws on this priority area in its Women’s Health Outcomes Framework, nominating violence as one of five priority areas in the social determinants of women’s health outcomes. The equivalent in Queensland states its “Women’s Health Policy was developed to complement the National Women’s Health Policy” while taking into account, “the state’s decentralised population, geographical isolation and related difficulties of health access” (Queensland Health 1993: 5). In Victoria, the Women’s Health and Wellbeing Strategy notes that the NWHP “implementation was instrumental in building on the established service system in Victoria” (DHS 2002: 7). Ultimately, it is state government health policy that provides the basic framework through which health service providers, including sexual assault services, are able to structure their approach to service delivery.
The influence of police

Although not a focus of this review, police remain one of the principal points of entry for victims who seek a criminal justice response, and therefore feature significantly in terms of the design and application of some of the inter-agency protocols reviewed here.

Increasingly throughout the 1980s, police operations and practices came under scrutiny in response to suggestions that police attitudes towards rape victims could largely explain the continued low levels of reporting (Freckelton 1988; Nixon 1992). High levels of disbelief, insensitive questioning and a failure to ensure victims received appropriate medical care and counselling support gave rise to immediate calls for specialised training and education for police members (Orr 1997). In Victoria, it prompted the adoption of a Police Code of Practice For Sexual Assault Cases, the first of its kind in Australia to co-ordinate a timely, sensitive and effective response from police, counsellors and forensic medical officers to victims of recent assaults that aimed to increase the confidence of sexual assault victims and the public in the police management of sexual assault cases (Heenan and Ross 1995).

Despite some important changes being instituted by police forces across Australia, the recent report of the Western Australian Ombudsman, An Investigation into the Police Response to Assault in the Family Home (2003), suggested that the different levels of awareness and personal prejudice carried by individual officers in handling reports of violence against women, continued to result in women receiving less than adequate responses. Examples included in the report referred to occasions of active bias by police against a woman reporting assault (2003: 10), apparent dismissal or minimisation of another report (2003: 14), and in another case it was suggested police employed an air of tedium when dealing with a victim (2003: 14).

A worker at a Women’s Refuge (2003: 14) confirmed how inconsistent approaches left workers feeling less than confident in knowing how victims would be treated:

“It depends on who you’ve got . . . some of the guys are excellent and do their job beautifully, and you couldn’t fault them. But there are others who think it’s a pain in the side, it’s a nuisance, it’s a disturbance, let’s get rid of it and move on . . . So it depends on who you’re working with . . . Some of them follow the letter of the law and others don’t.”

When police members in remote areas are known to be less than sympathetic to victims, the impact on communities is profound. It is, nonetheless, encouraging that the same document also reports specific examples of appropriate responses to family violence, particularly by individual Domestic Violence Liaison Officers in the Western Australian Police Service (WAPS). Some of those stationed in remote regions also dealt sensitively and appropriately with issues around diversity and distance as part of their regular policing duties, rather than see them as barriers to “good police practice” (2003: 38). At the conclusion of her report, the Western Australian Ombudsman’s strong recommendation is for the police response to be “uniformly regulated via a Minimum Standards Protocol approach” (2003: 47).

While it is still the case that police members maintain significant control over the steps that are taken following a report of sexual assault, in general terms, there appear to have been significant improvements in the police handling of sexual assault (VLRC 2003). This is particularly the case for those sections of police that have developed a specialised role in responding to reports of sexual offences. Nonetheless, there are studies that continue to attest to problems with the detectives in charge of investigating sexual offences.
According to Jan Jordan’s (2004) study of police decision-making in New Zealand, investigating police are sometimes basing their charging decisions on inappropriate judgements about the victim’s credibility before having conducted a thorough investigation of the allegations. These kinds of attitudes and practices were also evident amongst the discussions recently held with Victorian detectives (VLRC 2004), a number of whom suggested disproportionately high numbers of false reports amongst those claiming to be the victims of recent assaults. The extent to which these kinds of attitudes work to undermine and subvert both the spirit and the intention of existing health care protocols, however, remains unclear.

The influence of victim/survivor perspectives

The urgent call to governments by women’s services to provide for an adequate response to sexual assault was principally mobilised through the testimonies of victims who repeatedly described insensitive and inappropriate treatment at the hands of police and forensic examiners. Liz Orr (1997) and Moira Carmody (1992) have each traced the history of feminist service development and the successes of the women’s movement in securing both resources and commitments from State governments for fundamental change to the traditional medico-legal response to sexual violence. The emphasis became one of services (including police) providing respectful care and support, informing victims about their legal and medical options, while naming the assault unambiguously as a crime (Carmody 1992; Edwards 1995; Orr 1997; Cook, David and Grant 1999).

As previously discussed, in building on victim/survivor’s testimonies about what constituted effective intervention, feminist services worked to develop models that were essentially “rights based”. The challenge has been to develop and maintain protocols with key agencies that observe these principles, whilst allowing victims to maintain control over decision-making processes with respect to their counselling, legal and health care options.

Influence of national standards of practice

The production of the National Standards of Practice Manual for Services Against Sexual Violence in 1998 (hereafter referred to as the “National Standards”), developed in consultation with over 80 services throughout the country, was a milestone in “represent[ing] the first Australian effort to document the nature of the professional response to which women, children and men are entitled following sexual violence” (Dean, Hardiman and Draper 1998: i). While the Manual is primarily geared to establishing “good practice” amongst service providers who work directly with women in counselling contexts, its purpose is to provide services, both specialist and generalist, with the tools to work sensitively with victims of sexual assault in any context.

Specifically, the Manual nominates standards of practice that cover issues such as: access and equity, direct service to individual adults and children and to groups, community education and professional training, planning and evaluation; the need for services to remain transparent and accountable; and the obligation of agencies to work towards structural reform or social change in the wider community’s treatment and awareness of sexual violence. Further, the Manual refers to the need for formal protocols between sexual assault services and police, and separately, between medical, including forensic, services.
Interagency sexual assault protocols

This section provides an overview of some of the protocols that guide state and territory health care and service responses to victims of sexual assault. It is by no means a definitive record of all of the documents, agreements or inter-agency guidelines that may exist between services around the country. However, it does offer some useful guidance for distinguishing the various formal approaches that have been designed and introduced to govern medical and health care responses in various contexts. Under-represented in this overview is an appreciation of the less formal agreements that exist, and the variety of other relationships that have been established between community services and health care providers with more marginalised groups and communities, but that remain unrecorded or unpublished.

The following table of interagency sexual assault protocols is supplemented with commentaries provided by services to ACSSA as part of its review of rural and regional responses to sexual assault (See Briefing Paper 3, Responding to sexual assault in rural communities, by Neame and Heenan 2004). A sample of services in both large regional settings and in smaller remote or isolated regions of Australia were asked to reflect on the particular challenges they faced in terms of being able to offer victim/survivors the services set out in interagency protocols designed for state wide application (Neame and Heenan 2004). The author of this review spoke further with workers in other service contexts to gain a wider appreciation of how different state and territory protocols worked in practice.

The table is divided according to the formal protocols that currently operate in individual states and territories, and are designed to identify areas of common ground. The documentation gives attention to whether specific reference is made to both sexual assault and family and domestic violence, the extent to which the protocols differ for disclosures in relation to recent or past assaults, and the influence that access and equity issues, such as cultural and ability-based barriers including language and the use of interpreters, may have had on the content of protocols. These issues are highlighted in more detail in the commentary following the relevant table sections, rather than in the tables themselves.

The table itself specifies: the name of the protocol or document; year of introduction and whether there has been any subsequent evaluation or review; the agencies who are party to the protocol; characteristics of victim/survivors for whom the protocol guides service (such as age, gender); training nominated for workers, or for implementation or induction, cross-agency awareness, or community education purposes; and specific approach governing the delivery and approach to forensic/acute care following recent sexual assault.

The level of detail presented in the final column has been included to highlight the variation in how forensic evidence or samples are collected and maintained. These are important differences given that they tend to circumscribe the options available to victims of recent sexual assaults, especially with regard to making a police report. For example, in Victoria, a forensic examination will only be undertaken where the victim has indicated her willingness to make a formal statement to police. In South Australia, a forensic examination will be offered and the samples properly collected and stored, for up to six months while the victim/survivor decides whether to go ahead with a police report. In some remote areas, forensic samples cannot be maintained at all unless there is lockable refrigeration on site. To this end, we detail the scope of the general practice in each state and territory.
The status of the inter-agency protocol in New South Wales remains in draft at this time so there is limited information about how well the state’s Health services, police and the public prosecutions office will coordinate this formalised approach to responding to reports of sexual assault. The document outlines the roles and responsibilities for each of the key agencies and makes general statements about the need for interagency collaboration. However, there are no specific guidelines to address how each of the key agencies might coordinate an appropriate response. Rather, the guidelines distinguish how each agency should undertake their exclusive role in responding to sexual assault. Appended to the guidelines is a copy of the Victims Rights Act 1996, or the Charter of Victims Rights. The guidelines also contain details of the Sexual Assault Investigation Kit (SAIK). Unlike Western Australia (see below), New South Wales police will arrange urgent transport for a victim of sexual assault to the local sexual assault service where “urgent medical attention is required” (New South Wales Interagency Guidelines: 11).

Other protocols referenced in the guidelines that provide assistance to agency personnel: New South Wales Police Investigation and Management of Adult Sexual Assault and standard Operating Procedures; Office of the Director of Public Prosecutions Policy and Guidelines. Local Coordination Committee Meetings, Sexual Assault Review Committee (SARC), and the NSW Adult Sexual Assault Interagency Committee, each of which has a role in liaison and reporting in respect of sexual assault matters, are described briefly in the guidelines.
### Queensland

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<th>Document title and jurisdiction</th>
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<tr>
<td>Interagency Guidelines for Responding to Adult Victims of Sexual Assault Statewide guidelines</td>
<td>2002</td>
<td>Queensland Health including public hospitals, GMOs, GPs and a network of specialist sexual assault services – govt and NGO. Queensland Police Service Office of the DPP, also Department of Families Dept of Aboriginal and Torres Strait Islander Policy Office for the Adult Guardian and Legal Aid Queensland.</td>
<td>Applicable within the context of non-consensual sexual activity between adults and apply to those victims aged 16 years and over. Section 1.3 Young victims aged less than 16 sets out authorities for contact in the event of contact with a victim aged less than 16 years.</td>
<td>GMO provides regular training to police on Forensic and Medical aspects of Sexual Assault and also to the DPP upon request. Sexual assault services also provide training.</td>
<td>Forensic Examiner Government Medical Officer (GMO) Sexual Assault Forensic Examination Kits Available from Government Medical Office Holding time for specimens 3 months Consent forms for: • consent to medical examination • release of information to police Request form for: • Results of medical tests to be sent to nominated practitioner or other.</td>
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There are approximately 29 services, statewide, that provide specialist sexual assault responses, and 17 of these are non-government organisations; however, there is no single peak body representing all sexual assault services in Queensland. Nonetheless, the Guidelines apply across the state and have the potential to capture a wide range of services given the protocols encourage interagency collaboration, the need for the development of local protocols and the importance of establishing local services relationships.

The Guidelines also point to the importance of relationships with allied agencies such as the Department of Aboriginal and Torres Strait Islander Policy and with family and domestic violence services. The Guidelines state the need for training to “highlight [the] respective roles and objectives” of parties to the protocol in joint training. The Guidelines also indicate that input from “relevant local services” should be sought in training.
Yarrow Place Rape and Sexual Assault Service describe their service framework as according with both the letter and the spirit of the National Standards of Practice. However, they far exceed the bounds of the national standards in terms of the delivery of health care services to victims and survivors of sexual assault. Yarrow Place provides extensive documentation and information to doctors responding to sexual assault. They also employ specialist medical staff to work “on site” at the service. Included in the information pack are practical tools such as checklists, request forms and pro forma letters (for example, for workplaces) that doctors can easily adapt in supporting individual women, as well as documentation, ranging from referral information, how to access interpreters, and dealing with child protection issues. Consent forms must be obtained with respect to: the release of confidential information, verbal translation, and other documentation regarding forensics issues. A unique feature of the Yarrow Place document is the information regarding referrals from correctional services prisons. Their relationship with police is only partially formalised through a memorandum of understanding; however, at this stage the Memorandum of Understanding does not extend to standardising the coordination of the police response at an operational level. In other words, the police are not subject to working within the parameters of guidelines that formalise the precise manner in which police will respond to reports of sexual assault, nor does it prescribe how police will coordinate their response with counsellors or doctors who deliver services at Yarrow Place.
The Perth Sexual Assault Referral Centre (SARC) has actively engaged with the principles of the National Standards in developing its approach to service delivery. The drafting of their protocol, the *Management of Alleged Sexual Assault Information for Metropolitan Emergency Departments*, occurred in consultation with personnel from Emergency Departments across metropolitan hospitals in Perth. The document was developed to address the concerns of Emergency Department personnel about having the capacity to respond to Emergency Department presentations of sexual assault.

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<tbody>
<tr>
<td>Sexual Assault Resource Centre, Perth. Located at King Edward Memorial Hospital, which forms part of the campus of the Women’s and Children’s Health Service. Management of Alleged Recent Sexual Assault: Information for Metropolitan Emergency Departments.</td>
<td>2003</td>
<td>This document is a guide to metropolitan Emergency Departments (EDs) and their interaction with Perth SARC. The SARC has no ED facilities for medical, psychiatric, or obstetric emergencies.</td>
<td>13 years and over for medical and or forensic assessment if the alleged assault occurred less than 2 weeks ago. If the assault was more than 2 weeks ago and medical issues have been addressed victim/survivors are referred to the 24 hour SARC counselling line 9340 1899.</td>
<td>Medical and forensic training is provided by SARC doctors to police and relevant community and Health Dept. agencies. Police receive training at academy level for both recruits and detectives. Tailored training is provided to communities by arrangement with SARC. Training is also provided by SARC doctors to remote area community workers, and information and assistance is provided to remote area communities situated along the WA/NT/SA border regions. Education is provided to doctors and medical students.</td>
<td>Forensic Examiner SARC doctor</td>
</tr>
<tr>
<td>SARC Manual and local inter-agency protocols or agreements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sexual Assault Forensic Examination Kits Available from Perth SARC. Holding time for specimens 3 months minimum with a possibility of longer dependent upon available secure storage space.</td>
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Feedback from regional – very remote areas of WA indicated that some local adaptations to the SARC protocol are implemented to accommodate local conditions and resource levels. The following row is a summary of that feedback.

| CIB Department of Community Development (DCD) | All victim/survivors of sexual assault and family and domestic violence. State-wide mandatory reporting requirements for children up to 16 years of age. | Can be reliant on a sole worker – generally a social worker at the hospital. | Trained forensic professionals with expertise in sexual assault examinations are rare in very remote WA. The SARC doctors can guide another doctor through the forensic collection by telephone. One remote area worker reported to ACSSA that on occasion it might be necessary to travel to Perth for a forensic exam. | As for Perth. Lockable storage fridge for held specimens in local hospitals. |

The Perth Sexual Assault Referral Centre (SARC) has actively engaged with the principles of the National Standards in developing its approach to service delivery. The drafting of their protocol, the *Management of Alleged Sexual Assault Information for Metropolitan Emergency Departments*, occurred in consultation with personnel from Emergency Departments across metropolitan hospitals in Perth. The document was developed to address the concerns of Emergency Department personnel about having the capacity to respond to Emergency Department presentations of sexual assault.
victims. It is intended as a brief reference document to guide initial contact with victims who present at Emergency Departments. The title of the document itself reflects the tentative nature of Emergency Department personnel and their concerns to “manage” the clinical needs of “alleged” sexual assault victims. This exemplifies what is anecdotally expressed by many doctors as representing the fine line between medical professional concerns to administer sensitive and sympathetic care and doctors’ apprehension about appearing partisan or somehow compromised in their capacity to give impartial expert evidence should they be called to defend their findings in a courtroom. This concern is expressed by medical professionals throughout Australia and is taken up again in section three of this paper.

Crisis calls to Western Australian sexual assault services are triaged (emergency assessment and referral) through a system called Health Direct. Health Direct is staffed by nurses who assess the medical needs of the caller and direct the call to the appropriate service; either an Emergency Department if serious physical injury, acute psychiatric illness or intoxication is present, or to a sexual assault service for medical, forensic and counselling responses. In Perth the latter will mean being directed to the SARC, in regional or remote areas where there is no sexual assault service it may mean being directed initially to an Emergency Department and then to a social worker or community health service, or health nurse for follow-up. As with many aspects of protocols in Australia, the Western Australian triage system is still evolving. As the Coordinator Medical/Forensic Services at SARC notes: “The principles of tailoring the service to the needs of the individual are paramount. [Too] many people do not access services at all, particularly Aboriginal people. We need to be as ‘user friendly’ as possible” (Correspondence with ACSSA, August 2004).

Perth SARC provides a range of kits and materials to other services. These include female and male forensic sample collection kits that contain, for example, the appropriate swabs, labels, slides and a guide to maintaining an intact chain of evidence in the collection and handling of forensic samples. These kits are generally kept on hand at regional and remote hospitals throughout Western Australia. The SARC Manual details the procedure for a complete forensic assessment and for maintaining the legal requirement of ensuring there is a “chain of evidence”. It includes a consent form for each component of a forensic assessment including physical and genital examination, collection of forensic specimens, non-genital photography, release of specimens to the police, verbal and written report to the police.

The WAPS are involved in the development of protocols involving police matters. Meetings are held with the Major Incident Group and the Child Abuse Unit of the WAPS. The King Edward Memorial Hospital, which forms part of the campus of the Women’s and Children’s Health Service, has not been directly involved in meetings with the police. SARC itself, however, has a close working relationship with the police. SARC and WAPS have tended to meet prior to either service changing protocols in order to include the views of the other service and consider the impact of any decisions. The arrangement has been ad hoc but plans are in place to have regular meetings (Dr Maureen Phillips communication with ACSSA).
Tasmania

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<tbody>
<tr>
<td>Policies and Procedures for After hours and On Call Responses: Sexual Assault Services and Support (SASS) Hobart. Hobart and region</td>
<td>June 2001 Currently under review, anticipated revised Policy and Procedure by 2005.</td>
<td>SASS and Sexual Assault Medical Service (SAMS) Unit at the Women’s and Children’s Section of the Royal Hobart Hospital, Tasmania Police Hobart. Review group: Forensic Service Delivery Working Party.</td>
<td>People over the age of 13. State-wide, Under 13 yo – children are referred to paediatrician Dr Liz Hallam at Royal Hobart Hospital.</td>
<td>Training provided by SASS community education to Tasmanian police recruits and CIB Doctors Nurses Relevant community agencies</td>
<td>Forensic Examiner SAMS Medical Officer: One of five rostered doctors (currently, all are GPs). During BH During business hours the Obstetrics and Gynaecology Registrar will attend female sexual assault victims; Male victims will be attended by the department of Emergency medicine. Sexual Assault Forensic Examination Kits Available from Hobart SASS Holding time for specimens 6 weeks</td>
</tr>
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Tasmanian sexual assault services reference their statewide protocol as subscribing to the National Standards of Practice. Individual protocols have only recently been developed for the three main regions – Burnie, Launceston and Hobart – and each have particular local concerns that are reflected in how the protocols have been developed and implemented. While the protocols in Tasmania have only recently been implemented, the Hobart region is keenly examining how the protocol works in practice. The Forensic Delivery Working Party includes representatives from the hospital, the Hobart sexual assault support service and police. The mechanism that currently drives the approach to forensic care is the Sexual Assault Investigation Kit that includes a consent form that will allow any forensic samples to be destroyed should the victim ultimately decide against proceeding with a police report.
Victoria’s “Guidelines for Service Providers” apply for those who work with both adult and child victims of sexual assault. They outline and broadly define the working relationships between the 14 Centres Against Sexual Assault (CASAs), the Victorian Institute of Forensic Medicine (VIFM), the Gatehouse Centre at the Royal Children’s Hospital and the Child Protection Unit at the South Eastern CASA. The working agreement was established between agencies in August 2001 and further reviewed and ratified in August 2003. The Guidelines are said to exist as complimentary to the Police Code of Practice, the CASA Standards of Practice, the VIFM manual and the various hospital protocols.

The stated objectives of the Guidelines have remained “rights focused” in that all victims should anticipate that their rights to safety and protection are fully respected in the context of receiving a crisis care response. The functions of each of the key agencies are broadly distinguished throughout the document with an emphasis on articulating the principles that should underlie the approach to service delivery that ought to be taken by counsellors, police, and doctors in the context of crisis care intervention. A separate section is devoted to the issue of providing crisis care to children, and to outlining procedures for making complaints should there be any concern about the conduct or the manner in which services were provided.

Perhaps what most distinguishes the approach governed by the Guidelines in Victoria is the limitation imposed on accessing forensic care. Forensic examinations are only provided to victims who have made the decision to report to police. There is currently no provision for samples to be collected should the victim later decide to report (e.g. such as South Australia’s “Just in case kits”). This is highly problematic for victims of recent assaults who are often still suffering the effects of shock, or may feel ambivalent about making a decision to pursue a criminal justice response so soon after experiencing an assault.

Regional variations to this include some CASAs having established panels of doctors in their local communities who function as part-time forensic medical officers. Some of these doctors have become amenable to undertaking a forensic examination, and collecting the relevant samples, in situations where the victim remains undecided about involving the police. The samples are appropriately stored until such time as the victim indicates whether to formalise a police report.
Responses to sexual assault are managed across three regions: Darwin (urban and remote, including East Arnhem Land and Katherine), Tennant Creek (Barkly region), and Alice Springs. The protocol described in the table applies only in the Darwin Urban region. The “toxicology protocol” is one of two primary protocols employed by the Darwin Sexual Assault Referral Centre (SARC). The second protocol, “A Coordinated Response to Childhood Sexual Assault in the Top End”, applies Territory-wide. However, there is no formal Territory-wide protocol applicable to responding to adult victim/survivors of sexual assault.

Territory sexual assault services all reference their practice against the principles contained in the National Standards. Informally, SARC workers and doctors use an after-hours prompt sheet to ensure consistent responses. In the absence of a formal Territory-wide protocol for responding to adult sexual assault, the three regions have established close working relationships across sexual assault services, and locally each service works collaboratively with other agencies.

A position has been created within the Women’s Health Strategy Unit of Health and Community Services for a Territory-wide coordinator for the oversight of sexual assault services. At the time of writing this paper, however, that position had not been filled.

The Darwin Urban toxicology protocol is noteworthy in its scope for collaboration. For example, it is perhaps unique across Australia, for including the Australian Hotels Association as a signatory to a protocol for responding to sexual assault. Indeed, hotel staff in Darwin receive formal training from SARC workers. This particular protocol was developed in response to SARC figures indicating a rising number of drug-facilitated sexual assaults in the Darwin urban area during 2002. Amongst the findings were figures that suggested one third of adults and seven percent of children “underwent toxicology tests due to circumstances of rape where [a] drug or drugs were considered to be used to facilitate the assaults” in the twelve month period leading up to the development of the protocol. A number of the children who were drugged and assaulted were less than ten years of age.12

As with most other protocols reviewed by ACSSA, the Darwin Urban toxicology protocol is focused primarily, but not exclusively, on recent or acute sexual assault. While Darwin SARC provides services to victim/survivors of past sexual assault, and this is made clear in the section of the protocol outlining the role of SARC, the emphasis of the protocol deals substantively with managing the impact of recent sexual assault.
The main aims of the protocol with the Sexual Assault and Child Abuse Team within the Australian Federal Police is to provide a coordinated approach to the handling of sexual assault in the Australian Capital Territory, minimise the trauma experienced by sexual assault victims during the investigative process, clarify roles and responsibilities and ultimately increase the current poor rate of reporting of sexual assault to the police, by improving the confidence of the public and sexual assault survivors in the police and legal processes.

This protocol needs urgent reviewing as there has been changes recently to the reporting procedure for sexual assault victims. Victims currently attend their local police stations to make their initial report of sexual abuse. The police officer on duty will make a decision whether to forward this information to the Sexual Assault and Child Abuse Team. The Canberra Rape Crisis Centre (CRCC) has concerns regarding the nature of the training that local police currently receive with respect to providing appropriate responses to victims and survivors of sexual assault and abuse. While the CRCC provide training to new recruits, they are not involved in the training of other police officers who may work with a victim of sexual abuse.

The services covered by the Memorandum of Understanding with the Forensic and Medical Sexual Assault Care (FAMSAC) include: forensic medical services in cases of adult sexual assault, post assault medical examination for those who do not wish to proceed with a forensic medical examination after a sexual assault, medical information reference centre for staff of the Canberra Rape Crisis Centre and the Service Assisting Male Survivors of Sexual Assault (SAMSSA), and support and advocacy for survivors of sexual assault.

In previous years, forensic examinations could only be carried out by Commonwealth Medical Officers who were invariably male. Recently, there was a push to encourage women doctors within the ACT to receive the training required to perform forensic examinations. There is now a pool of women doctors available on a roster system to provide forensic examinations when required by women.

The Canberra Rape Crisis Centre auspice the Service Assisting Male Survivors of Sexual Assault (SAMSSA). This means that the CRCC manage the financial and employment aspects of that service. The CRCC has a representative on the SAMSSA Reference Group which oversees the direction of the service. The CRCC provides services to male victims up to the age of 16 years and will then refer to SAMSSA. Both services work collaboratively to provide a service for women, men and child survivors of sexual abuse. Joint training and information sessions are available on request for government and non government organisations.
PROTOCOLS IN CONTEXT: CASE STUDIES

The protocols guiding the health care response in both Victoria and Queensland will be considered here in detail. Protocols in Melbourne (Victoria) and Townsville (Queensland) have in common their genesis in the activism of women survivors and service providers. In the Victorian context, Liz Orr has documented the tensions between the service sector and the bureaucracy in her study of the establishment of services against sexual assault in Victoria (Carmody 1992; Orr 1997). The Townsville experience is documented in several conference papers (Brazier, Killey and Promnitz 2001). Together these examples highlight how the initial lobbying for changes to the treatment of sexual assault were fiercely pursued and defended by women advocating a strong victim’s rights agenda. The legacy of this approach resulted in the development of protocols firmly based within feminist theory and practice.

While their origins shared much in common, their road to establishment ultimately differed quite dramatically. Firstly, there are the obvious geographical differences. Townsville is a regional city hundreds of kilometres from its State capital in Brisbane while Melbourne is the capital city of Victoria. The Victorian model has been in place long enough for some review and evaluation to have taken place (Heenan and Ross 1995), while the model in Townsville has been developed and implemented relatively recently. The Victorian model grew out of the women’s movement of the late 1970s and 1980s when research about the extent and impact of sexual violence was reasonably limited, whereas Queensland has been able to rely on a plethora of studies that reliably speak to the prevalence and wide ranging impacts of sexual violence on victims and on communities. The social and political climate in which each model developed was also very different.

The Women’s Centre in Townsville is one of a loose network of agencies in Queensland responding to sexual assault. There is no one peak body representing the interests of all services against sexual assault in Queensland and the services themselves are funded either directly through Queensland Health and operate as government services or they are indirectly funded and operate as non-government organisations, somewhat independent of government policy. By contrast, the coordinators from the 15 Centres Against Sexual Assault in Victoria meet monthly as the Victorian CASA Forum to address issues at a state level.

The following case studies briefly trace the development of the two agencies and the protocols they sought to establish. They are, however, by no means an exhaustive account.

Case study

Melbourne Centres Against Sexual Assault (CASAs)

The Victorian experience of establishing sexual assault services grew from a comprehensive and considered campaign that began in the late 1970s. The political and social climate converged at a time when women were agitating through groups such as the Victorian “Women Against Rape” and the Women’s Electoral Lobby to effect change. The moment was ripe for building on a political platform that was becoming more attuned to the particular social conditions under which women laboured (McCarthy 1990; Orr 1997). Particularly compelling were the
accounts of women who were increasingly shown to be reporting sexual assault to a system that frequently retraumatised them.

In 1977 the Federal Royal Commission on Human Relations “made extensive recommendations regarding the provision of medical services and protocols for assisting victims of rape” (Carmody 1992: 15; Orr 1997: 62). In 1978, the Queen Victoria Hospital was funded to provide Melbourne’s first Sexual Assault Clinic, which was subsequently re-established in the early 1980s at the Royal Women’s Hospital. This proved to be a defining moment for women’s services to carve new ground upon which services run for and by women in responding to sexual assault would be given the imprimatur of the state.

According to McCarthy (1990: 6):

“In considering its role in the community, the hospital was recognising the push of the women’s health movement toward a social model of health, towards new kinds of service models . . . It was in this climate that the Royal Women’s Hospital … aligned its motives with women in the women’s movement, [and] a process was commenced for developing an alternative service model.”

The requirement of establishing a model that first respected and responded to the specific experience of women, and second, that could simultaneously challenge the social structures that supported the social environment under which sexual assault remained hidden and barely sanctioned, was at the foundations of the framework subsequently developed and that underpinned the ethical standards that were to become enshrined through the service approach adopted at CASA House.

Again, according to (McCarthy 1990: 7):

“An explicit philosophy underpins the operation of the Centre Against Sexual Assault. This philosophy commits us to defining sexual assault as a social and political phenomenon, not as an individual pathology.”

It was this conceptualising of sexual assault as a phenomenon that impacts on the collective experience of all women\(^\text{13}\) than an isolated event resulting in “an individual pathology” that most distinguished the service models established at this time from the medical or therapeutic model of “treatment” or “management of sexual assault cases” that had historically directed mainstream medico-legal responses.

*Services to Adult and Child Victims of Sexual Assault: Guidelines for Providers* is the protocol developed between the Victorian Institute of Forensic Medicine (VIFM), Victorian CASAs, the Royal Children’s Hospital – Gatehouse Centre and Monash Medical Centre, Child Protection Unit, and South East CASA. The guidelines outline the roles and responsibilities of the respective services in responding to sexual assault and assume adherence to the Victoria Police Code of Practice for the Investigation of Sexual Assault, the National Standards of Practice, the VIFM Manual and the relevant hospital protocols. The guidelines also outline the objectives of providing respectful service to victim/survivors of sexual assault in a coordinated and comprehensive manner.

The tenuous nature of the recognition of sexual assault as a serious harm to women, and as a major public health issue, is perhaps exemplified in the experience of the Townsville community in much more recent times.
Case study

Townsville, “We’re going to light the bloody thing ourselves” (Keally and Killey 1996)

In 1995 a Townsville woman was raped during an attempt on her life. In 1996 in a co-presentation to a national conference on sexual assault she described, amongst other things, her experience of the forensic examination carried out that same night as being “subjected to . . . further degradation, humiliation and violation”. Her co-presenter fleshed out the details of the problems they saw besetting the medico-legal process in Townsville at the time:

- Women have been kept waiting for hours because the GMO stated they are not to be contacted overnight for sexual assault forensics;
- A forensic examination conducted from start to finish in 20 minutes;
- No explanation provided and women not asked for their consent to any of the procedures;
- Women left naked and uncovered for the entire examination;
- No prophylactic information or medical follow-up offered or advised; and
- No training given to GMOs in how to provide appropriate care and support to victim/survivors prior to taking up their roles.

These two women, Lu Keally and Catherine Killey, determined to act on these and other legal issues founded the core group of people, from a range of agencies and interest groups, that were to convene in 1996 to address the short-comings of the treatment received by women in the aftermath of sexual assault.

In August 2001 the Townsville Sexual Assault Response Reference Group (SARRG) presented a conference paper titled “Inter-agency Responses to Sexual Assault” detailing SARRG’s development and activities since its inception in 1996 (Brazier et al. 2001). SARRG’s approach demonstrates how grassroots activism and collaborative efforts across agencies can be a powerful mechanism for driving localised change. The interagency collaboration between the Queensland police, the Director of Public Prosecutions, General Practitioners, Accident and Emergency staff, and women’s support services (in combination with survivors themselves) resulted in a Government Medical Office opening in Townsville in 1997, followed by the development and implementation of Queensland Statewide guidelines in 2002.

It seems that the group has had a considerable impact not only on responses to sexual assault in the local Townsville area, where an increased reporting of sexual assault has followed the work of SAARG, but, according to Brazier et al. (2001):

“In the 18 months following [the commencement of SARRGs lobbying], Townsville Police showed a 58 per cent increase in women reporting [sexual violence] crimes. It was not indicative of an increase in crime because the majority of the reports were of an historical nature showing that the services were seen as more appropriate and supportive and enabling survivors to come forward after living with trauma for a long time.”

The SAARG has also influenced the development, at a statewide level, of Queensland’s Interagency Guidelines for Responding to Adult Victims of Sexual Assault: “The work carried out by SARRG provided the basis for Queensland Health in the formulation of the new protocol document” (Brazier et al. 2001: 4).

The Queensland Guidelines refer throughout to the importance of interagency collaboration with localised specialist agencies in ensuring effective service
delivery to victim/survivors. The guidelines make specific reference to the incidence of sexual assault in intimate relationships and refer to alternative protections available under Queensland law (Queensland Interagency Guidelines for Responding to Adult Victims of Sexual Assault: 27 para 4.4.15).

A comprehensive list of support agencies is attached to the guidelines and includes domestic violence support services. The experience of the SARRG is testament to the benefits of collaboration of agencies at a local level. The authors report that the police treatment of victim/survivors has improved due to their involvement in SARRG and subsequent exposure to feedback about “inappropriate, judgmental and insensitive responses towards survivors of sexual violence” (Brazier et al. 2001: 2). The SARRG also provided an opportunity for Townsville agencies to share protocols and to review what worked best to support the needs of victim/survivors (Brazier et al. 2001: Conference paper abstract).

The Queensland Sexual Offences Medical Protocol includes detailed documentation of the procedure to be followed in the event of a forensic examination and includes consent forms for the release of information to Queensland Police. A form to request that the results of tests be forwarded to a nominated health practitioner or other person is also included in the Protocol. The Protocol is provided along with specimen collection materials and instructions for the handling and handover of specimens and information to Police and forensic science agencies.

The Queensland example is important because it illustrates the contemporaneous nature of the struggle to implement and maintain consistent and appropriate service provision in response to sexual assault.

DISCUSSION

In sections one and two of this paper, we explored the historical development of protocols in Australia and outlined the details of inter-agency protocols as they currently exist. This final section is in two major parts.

First, we examine some of the common themes that have arisen out of this snapshot view of health sector protocols and ask how the protocols remain relevant to the work of health, support, and legal agencies, and what might be done to improve their effectiveness?

In the second part we analyse recent Australian and international research that examines the profound impact of sexual assault on the individual lives of (mostly) women, on families, and on communities and the significance of these studies in considering any future re-design of inter-agency protocols that respond to victims’ long-term health care needs.

Effectiveness of protocols

The agency perspective

While some of the protocols, at least in principle, begin to address the concerns of victim advocates as well as take into account the issues raised by research over the past three decades, there are a number of limitations, at an agency level, that
effect their implementation. A significant finding of this paper is the variation in understanding, within any particular sector, of the applicability of protocols. Three major city-based services suggested that their protocols tended to direct the service-response provided by agencies outside of major city areas and were not in fact, for varying reasons, applied directly within their own services.

The extent to which the inter-agency protocols were known about and/or adequately applied across health, sexual assault service-providers and legal agencies was certainly uneven according to staff at several sexual assault support services. In general, senior staff across most of the key organisations appeared to have some knowledge and understanding of the protocols they operated under (and were signatories to), although there were occasions when individuals were clearly unsure of the status or existence of claimed to have no knowledge at all. On other occasions, sexual assault workers suggested that agencies that were unclear about the status of interagency protocols, sometimes gave deference to the manuals and procedures that more broadly governed the service response of the organisation. For example, hospital emergency department workers might refer to “in-house” hospital procedures, while police might direct attention to their operating procedures manuals as over-riding the status of any other type of document.

Another factor impacting on the effectiveness of protocols is the extent to which collaboration between agencies has genuinely been achieved. Integrated health service delivery models, like those found in Sydney, Perth, Hobart and Adelaide, have been most effective in streamlining the extent to which victim/survivors will be obliged to repeat the details of their abuse. These integrated health models offer forensic and counselling services on the same premises, either attached to, or close by hospitals where emergency departments can provide medical treatment for serious injury. Pregnancy and STI testing and the provision of prevention and amelioration measures such as emergency contraception counselling services, follow-up medical care, and short-term counselling for acute or recent sexual assault, are all provided in an environment of relative security and comfort.

Another advantage of such an integrated model is the opportunity for increasing specialisation and professional development in sexual assault service provision afforded to medical personnel. The Melbourne metropolitan CASA model meets this concern to a certain extent. Hospital services are located close-by where all medical and follow-up medical health care can be accommodated. Counselling is provided in a discrete non-medicalised environment, similar to the Sydney, Perth, Hobart and Adelaide services. Brisbane, Townsville and Gold Coast services in Queensland also provide similar services.

However, a high degree of collaboration amongst colleagues from different disciplines (for example nurses, doctors and counsellors within services) is a prerequisite for the effective implementation of this integrated kind of model. Genuine efforts to work collaboratively is not always possible. For example, emergency department personnel at some of the hospitals considered do not share this type of close collegial relationship.

Furthermore, the advantages of the integrated model are not available outside major metropolitan centres, and protocols designed with this model in mind may not always be appropriate to regional and remote services. For example, the requirement in Victoria to provide medical and forensic services within two hours of a report being made, for instance, is no simple matter when the only means of access to services for the victim is via plane or boat.
As a worker from one sexual assault service noted:

“Access to forensic examinations is difficult. A victim might travel a couple of hours to a police station, from which they may be taken to another to be interviewed by CIB (again a couple of hours drive), and from there might have to be driven another couple of hours to be examined by a Doctor, back to the station for a second time, then back home.”

Many island communities all around Australia have no specialised on-site services for responding to sexual assault. Even where there are a number of services that might separately be able to provide a health care response to sexual assault, in more isolated regions, they may not have established the mechanisms through which they can better co-ordinate their responses. This is of course also true in some major city areas, although not for the same reasons. Even where protocols are able to be applied, and can be adapted to localised situations, there is often an issue of accountability. Few of the inter-agency protocols had been subject to evaluation or included formal mechanisms for monitoring compliance.

It must also be acknowledged, however, that the existing inter-agency protocols may be fundamentally inconsistent with the kind of approach that might be more culturally appropriate to meet the needs of particular communities. At least two Indigenous communities, according to the workers in these regions, have begun to consolidate their own programs for dealing with violence against women. These programs bear philosophical similarities to the major city protocols but operate in distinctively community-based ways with specific reference to the skills of community elders rather than be accountable to the government departments.

Flexibility is also important in those regions where forensically-trained medical staff must substitute for doctors where none are available, or where doctoring is variable due to high turnover rates. While the allocation of sufficient resources to training and recruitment could conceivably address the shortfall of trained specialists, the need to more permanently place specialists outside of the major cities areas is well recognised. Interest in the training of nurses to provide forensic services is increasing in Australia. Recommendation 7(a) of the report by the Department of Health and Human Services (DHHS) in Tasmania, titled *Justice Matters*, is “considering adopting or adapting the American model of Sexual Assault Nurse Examiners (SANE) in sexual assault cases” (Davies 2002: 10).

A recent report from the United Kingdom, *Forensic Nursing: An Option for Improving Responses to Reported Rape and Sexual Assault*, concludes that “forensic nursing can provide a cost-effective option to: address delays in the provision of forensic examinations; increase the availability of female forensic examiners; and also has the potential to enhance professional standards” (Regan et al. 2004:1). Nurses have previously been able to access specialist forensic training in Australia. For example, the doctors employed by the rape and sexual assault service in South Australia, Yarrow Place, currently deliver training in forensics where some of the participants in the course have been nurses (some from remote areas). The difference with SANE training is that it is a program developed specifically for professional nurses. SANE nursing certainly provides one option for addressing some of the issues arising with the paucity of forensic expertise in regional areas.

In discussing the effectiveness of the inter-agency protocols, a majority of workers were nonetheless enthusiastic or hopeful about the protocols improving the working relationships across agency groups. This is perhaps best demonstrated by
the continued goodwill between parties to existing protocols, and their willingness to continue developing practices according to perceived needs of victim/survivors and of the system. Nonetheless, it is important for agencies to have access to “evidence-based” understandings of how the protocols are working in practice if the inter-agency protocols are to remain relevant to the needs of individual victims.

**The victim/survivor perspective**

How successful the individual protocols may have been for ameliorating the difficulties originally identified by victim survivors has not been comprehensively assessed. Some information can be gleaned from surveys (Heenan and Ross 1995; D’Arcy 1999), or through listening to the testimonies of victims about their contact with services following disclosure (see for instance, Keally and Killey 1996; Kripps 1996).

The Victorian evaluation of the Police Code of Practice was certainly helpful for being able to identify problems of non-compliance early, and ensuring that the Code did not lose momentum in shaping more workable relationships across the key agencies involved (Heenan and Ross 1995). It also meant that the principles of prioritising the victims needs (medical, emotional and legal) were further endorsed. Other protocols, such as the Queensland Guidelines, have built in the requirement and the resources for ongoing monitoring. There is the potential in this context for greater attention to be given to how relevant and effective the guidelines continue to prove, and to monitor any changes in practice, service use, and victim satisfaction.

**Sexual assault and health: International research and policy directions**

The health effects of sexual violence have only recently emerged as an area of concern in public policy terms. It is now clear that violence against women is a primary indicator of women’s health outcomes across the life-span. Here we look briefly at international and Australian research into what is fast becoming a compelling evidence base that reliably links women’s ill-health with the incidence and prevalence of domestic violence and sexual assault. We consider at the implications of this overview for ongoing development and practice of agency responses to sexual assault in the health sector, and for specific sexual assault protocol development and implementation.

**Public/community health and sexual violence**

The effects of sexual assault and other forms of violence take a significant toll on the health of entire communities. In Australia this was reliably illustrated in the recently-published report by the Victorian Health Promotion Foundation (hereafter VicHealth) titled “The health costs of violence: Measuring the burden of disease caused by intimate partner violence” (VicHealth 2004). The report confirms what women survivors have been telling us for decades, that sexual and physical violence has an enduring impact on their health.

Indeed, the study found that: “Intimate partner violence is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking” (VicHealth 2004: 8).
Internationally, the World Health Organisation (WHO) has held a series of conferences looking at public health over the past three decades and now recognises the impacts of violence against women as one of the most significant health issues facing world communities. Research considered by World Health Organisation and the Global Forum for Health Research have identified the health burden of sexual assault and violence against women as greater than the combined effects of malaria and traffic accidents (WHO 1997, vol. 4).

Moreover, there have been moves in recent decades to position health with the language of human rights. In 1978 the International Conference on Primary Health Care, meeting in Alma-Ata made the following Declaration (in part):

“The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right” (Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978).

The Ottawa Charter for Health Promotion in 1986 also recognised that public health policy is central to providing the conditions in which communities can build flexible and sustainable partnerships aimed at addressing health concerns. The Charter further notes that this requires “full and continuous access to information, learning opportunities for health, as well as funding support” (Ottawa Charter for Health Promotion 1986: Strengthen Community Action).

The collective findings of this research confirm that sexual violence is preventable and generates serious and ongoing consequences for the health and wellbeing of individual victim/survivors, has a calculable cost to the whole community both in financial terms and in terms of the health of communities, and requires a proactive, determined focus on the part of government and community in order to reduce and ultimately eliminate it. The role that health sector protocols can play in this context cannot be underestimated in terms of ensuring the health needs of victim/survivors are met, throughout their lives.

We know that we have the capacity to respond as a community to serious and preventable health problems. An example is the enduring cultural change brought about by a concerted and sustained effort to address the alarming trauma and damage caused by traffic accidents. It is no longer culturally acceptable to drive under the influence of alcohol and many publicly funded campaigns aimed at reducing injury and death from speeding, driving while fatigued, and dangerous driving, have reduced the incidence of traffic accidents dramatically since campaigning commenced in earnest in the 1970s.

Given what research now shows us about the health burden of sexual and other forms of violence, it is not unrealistic to expect that we would respond with the same dedicated efforts to reducing the causes or contributors to the trauma and damage that results from violence. Campaigns aimed at primary prevention will require major policy commitments from all levels of government. On the other hand, health sector protocols may assist by providing earlier points of intervention through which victims may access support and more readily link their health status with their experiences of violence.

In 1997 the World Health Organisation declared violence against women and girls a major health and human rights issue (WHO 1997, vol. 4). International policy directions in addressing the health needs of those who have experienced sexual violence are reflected in Australian federal and state health policies as discussed in...
section two. In theory at least, Australian policy responses to the health needs of victim/survivors of sexual violence align well with international policy directions. This is also true in the specific instance of health sector protocols as exemplified in the major sexual assault services around the country. It could be said that they represent models of good practice. There are, however, a range of factors that continue to influence the practical application of these umbrella policies and these are explored further below.

**Limiting factors on health responses**

Specialist sexual assault services, including women’s health sector agencies, provide responses that address the core concerns of victim/survivor centred practice within a feminist framework. Individuals in other health services, as well as individual police members, are certainly striving to improve their practice in terms of responding appropriately to the needs of victim/survivors of sexual assault. Unfortunately, however, the overwhelming experience of women accessing health services for issues arising from sexual violence is that the health sector is generally ill-prepared and under-informed about the health issues victim/survivors face. Some services may in fact respond in ways that further compounds the effects of violence on victims by responses that are more informed by prejudice, than by understanding the social and situational contexts in which most sexual assault occurs.

Several Australian studies have documented some of the factors restricting or preventing appropriate responses by the health sector and other services, despite best practice policy and protocols. Surveys conducted as part of the Australian Longitudinal Study on Women’s Health, known widely as Women’s Health Australia, found that in response to questions about the effectiveness of help sought in instances of violence only “a relatively small proportion of the women were satisfied with the help they received when they asked for it” (Parker 2001:191). While the researchers are here referring to women’s experiences of domestic violence broadly, they nonetheless surmise that “the ability of health and police services to respond appropriately to women who have experienced violence and abuse needs improvement”. Parker goes on to note that there are possibilities for much improved outcomes for women experiencing violence with a “more proactive approach from health, social and police services” (2001: 191).

A major factor limiting the capacity of the health system to respond is the non-recognition of sexual violence as a health issue, and the lack of sufficient training and skills development to address health professionals’ awareness and capacity to respond appropriately. Research by Mazza, Dennerstein and Ryan (1996: 15) found that in a population of women attending their general practitioner, “importantly, about three-quarters of respondents [to the survey] had never been asked by their doctors about domestic violence or childhood physical abuse”. In the case of both adult and child sexual assault, 53 per cent of survey respondents had not disclosed to their doctor because they “had never found it relevant to the consultation” and for 27 per cent their doctor had never asked (1996: 15). Overall, among the 15 general practices in Mazza’s study sexual violence was grossly under-detected by doctors. As Mazza notes, not only are women not making the connection between their symptoms and sexual violence, neither are their doctors. She goes on to suggest that where the potential for abuse is overlooked in diagnosis, “treatment is likely to be inappropriate and potentially harmful” (Mazza et al. 1996: 17).

Others have commented on the paucity of medical professional recognition of the issue of sexual violence. Jenny Barry (1992: 48) observes that although “the community has been grappling with adult sexual assault for a long time . . .
medical profession has been notably silent in this area”. In recognition of the harmful impacts of under-detection or misdiagnosis of the health effects of sexual violence, the Australian Health Minister’s Advisory Council (AHMAC) undertook to address the lack of awareness and skills among medical professionals and commissioned the interactive educational module, *Medical Responses to Adults Who Have Experienced Sexual Assault* (Olle 2004). This module will be available to doctors across Australia in 2004.

The potential to redress this failure to identify and respond to sexual violence is perhaps one of the most heartening aspects of work in this field. According to the World Health Organisation (WHO 1997, vol. 9: 2):

> “Studies show that with proper training and protocols, health care workers can become more sensitive to issues of violence against women. One example is the emergency department of the Medical College of Pennsylvania, Philadelphia, PA, United States. After introducing training and protocols on violence, the proportion of female trauma patients found to be battered increased fivefold, from 6 per cent to 30 per cent.”

The impact of the lack of specialised knowledge and insight outside of sexual assault services is to limit the capacity of the whole health system to respond appropriately. On the other hand, it is hard to overstate the potential for vastly improved health outcomes across the spectrum both in terms of responding to individual victims and for the whole community.

A range of other factors also influence the practical delivery of appropriate health responses. Most notably these include where services are limited by: size or resource levels; geographic proximity to other (partner or specialist) service providers; adequate skills and training in relevant and appropriate service responses; and where the requisite will to respond appropriately does not prevail or cannot be monitored and adequately supervised.

Protocols are clearly one mechanism for reducing the extent to which individual factors can have a disproportionate influence on inter-agency responses. However, one significant and recurring theme to emerge in discussions with various workers was the extent to which the community profile of issues like sexual assault and intimate partner violence can sometimes be dependent on the attitudes and personalities of people living and working in the community itself (OSW 1998; Western Australian Ombudsman 2003; Neame and Heenan 2004). This factor may have the potential to drive efficient, appropriate and transformative service provision and greater recognition of the extent and effects of sexual violence on the community, or it may work to undermine effective responses. The particular values, insights and skills of workers can certainly influence the nature and approach to delivering services to victims of sexual assault and domestic violence in the local community.

Workers in some of the remote and very remote regions were careful to impress their awareness of the influence they themselves could have on a small and isolated community. One worker spoke of recently having left a position and speculated that it was time to move on because she felt it was possible that her personality and her style of response and interaction may, after some years in the area, have constricted community growth in directions she may not have
recognised. The case study of the development of guidelines in Townsville, in Queensland, is further testament to the idea of progress being firmly linked to the commitment and energy of a small number of very determined people.

Finally, long-term health care is not specifically addressed in many of the protocols reviewed here. This is hardly surprising given that so much of the early policy focus was on fundamentally improving the response that victims of recent assaults encountered at the point of crisis care. However, the contemporary climate also inhibits a longer term focus. Sexual assault services are typically funded to provide short-to-medium term counselling. Hospitals, in this context, are therefore responding to mostly acute and shorter-term medical issues. Non-government services such as Women’s Health Centres do provide a greater degree of longer-term support to women survivors through group programs and individual counselling, community development and public advocacy. However, this generally falls far short of assessing the kinds of life-span health outcomes that are increasingly being linked to women’s long term experiences of intimate partner and family violence. This will require vastly new ways of responding to the issues.

The cost of sexual violence and health responses

In terms of cost to the community, research conducted by the World Health Organisation (WHO 1997, vol. 8) around sexual assault indicates that:

“The costs to society of violence against women are tremendous, in terms of health care alone. A proportion of these costs are for treating serious physical injury. A substantial amount is also spent on psychological problems including managing anxieties and symptoms which happier, more confident, women may be able to tolerate, ignore or shrug off.”

They also cite costs in terms of systemic responses such as investigation and legal costs across the spectrum, rehabilitative programs for perpetrators, medical and social service costs (including child protection services), and costs associated with reduced productivity and employment.

The research that informs the reports written by Lesley Laing and Natasha Bobic (2002), Christina Lee (2001), and Vichealth (2004), also points to the false economy in under-funding specialist services to victim/survivors of sexual violence especially given that these services are also the prime motivators in community education, and in driving discourse about appropriate support responses and prevention. In their literature review of studies into the costs of FDV, Laing and Bobic (2002: 26) note:

“Several of the studies addressed the question of the proportion of costs of domestic violence borne by different parties. The Tasmanian and Northern Territory studies found that governments bear the largest proportion of direct costs and that women bear the largest proportion of indirect costs. This, however, may be a consequence of the similar methodologies applied in these two studies. The approach of the Brisbane City Council study (Henderson 2000a) is interesting in this respect, in that the point is made that the direct costs of services provided by government are in fact indirect costs to the business sector, incurred through taxation. The Tasmanian and Northern Territory studies make a similar point – that is, that the whole community incurs high costs due to domestic violence – by denoting the share of costs paid by governments as ‘community/government’.”

The particular values, insights and skills of workers can certainly influence the nature and approach to delivering services to victims of sexual assault and domestic violence in the local community.
In any event it is clear that there are significant costs to all sectors of the community as a result of sexual and other forms of violence. Whoever bears the ultimate cost, the imposition of the costs is largely preventable. However prevention relies on the dedication of adequate resources and a commitment in policy terms to ensuring the stability and permanence of services working on prevention, without undermining the capacity of organisations to provide direct service to women, children and men who have already experienced sexual violence.

Against the Odds (OSW 1998), reports that in the instance of family and domestic violence, “it needs to be acknowledged that existing domestic violence services are typically stretched to their limits, and that demand for assistance far exceeds the present service-capacity of most agencies and organisations” (1998: 94). Kate Baxter further addresses the issue of resourcing in her paper on rural services, titled Starting from Scratch (in Breckenridge and Carmody 1992: 177-179). To this extent, studies confirm that a growing awareness of the prevalence, seriousness and persistence of violence against women, along with the health and economic costs to both individuals and the community, is almost directly correlating with an ever-diminishing pool of resources. A consistent response from across the sector of sexual assault services is that resourcing is inadequate to the task of meeting the growing demand for direct service – that is, one to one counselling and advocacy, and the demands of community education.20

Concluding remarks

Health sector and interagency protocols aimed at providing consistent, professional and appropriate responses to sexual assault are relatively new features of the Australian health policy and practice landscape. In the afterglow of highly successful feminist lobbying throughout the 1980s, aimed at improving systems responses to women who were victims of sexual offences, services were keenly committed to establishing working agreements across agencies that would allow for victim's emotional, medical and legal support needs to be consistently met.

Lessons from overseas studies helped to shape the direction in which services in Australia would develop. In the late 1970s Ann Burgess and Lynda Holmstrom (1974a, 1974b) exposed the science of “rape trauma” that identified how immediate crisis intervention was more effective at dealing with the damaging effects of sexual violence. “Good practice” was seen to lie in agencies being committed to prioritising the emotional support and health care needs of victims regardless of whether s/he opted for police or legal intervention. National standards were formulated for workers in both specialist sexual assault services and other more generic health services that would consolidate a consistent service response to victims that was grounded first and foremost in practice, and where the rights of victims to determine any “next steps” were both supported and respected.

The mechanisms developed over the past two decades to guide inter-agency responses to sexual assault have attempted to coordinate service responses that manage what have historically been competing interests among, on the one hand, police and forensic doctors eager to maximise the potential for successful prosecutions and, on the other, counsellors advocating on behalf of victims to ensure their counselling and support needs are properly met. The influence of state and federal health policy in providing a backdrop against which protocols could be shaped was undeniably significant during the mid 1980s, alongside successful lobbying for improvements to police practices and calls for standardising good practice, nationally, across service agencies.
This ACSSA Issues paper has provided a snapshot view for services to look across state and territory borders to assess the kinds of protocols that currently exist to guide inter-agency responses to the health care needs of victims. The table was designed to illustrate graphically the particular mechanisms that operate in each jurisdiction, and included: the parties to the protocol, the point at which the protocol was first introduced, the circumstances under which each protocol is activated, requirements for training by services and individuals who are signatories to the protocol, and the nature of forensic or medical care provided.

In the relatively short life of the existing protocols in Australia, the emphasis has remained squarely on the need for early intervention to mitigate the potentially long-term harm caused to victims of sexual assault who are left unsupported or disbelieved. This is now reflected in the vast majority of protocols with forensic and emergency medical responses clearly positioned as central within each document.

However, maintaining acute or crisis care responses as the optimum focus for responding to the health care needs of victims has resulted in less attention being given to the potential for longer-term or life-span health effects of sexual violence for individuals. Where specialist sexual assault services generally maintain services for victim/survivors regardless of the time elapsed since the assault, protocols within the mainstream health sector do not explicitly acknowledge the need for responses over time or over life-spans. For victim/survivors for whom no initial acute response was possible or desirable, or for those for whom no response was historically available, the health sector is only now beginning to recognise the possibility of providing responses in the longer term.

The approach taken by Yarrow Place, the rape and sexual assault service in South Australia, is a case in point. The service is designed to ensure that women’s forensic and longer-term health care needs can adequately be met on site, regardless of when the assault occurred. Hence, women victims, who may months or even years after the assault endeavour to seek medical support, especially in terms of gynecological care, can continue to access the service at Yarrow Place and be assured of seeing a doctor who is both sensitive and aware of the effects of sexual violence.

Overall, this paper has demonstrated the importance of states and territories finding ways of evaluating their existing protocols that can allow for information-sharing across borders about how to progress or re-develop approaches to service-delivery in the light of new developments in the field. Moreover, following the emergence of research that reveals the compelling association between the health impacts of sexual assault and other forms of intimate and familial violence, greater attention must now be given to developing training for general practitioners and other workers within the health care system to raise their awareness and capacities in being able to identify and respond to health issues that can emerge as a result of being exposed to experiences of violence. It is here that the greatest scope lies for further developing health sector protocols that can better guide responses to both recent and past disclosures of sexual assault, in a bid to improve on the health outcomes for the vast majority of victim/survivors.

The way is open to build on the important lessons learned in the development of systemic acute responses and to more fully integrate the whole of life experience of individuals who experience sexual and physical violence. The health and well-being of victims, and the community at large, depends on it.
Endnotes

1 A fourth element of responses to sexual assault includes informal networks such as family, friends and peers of victim/survivors. This network is specifically acknowledged in some protocols (see, for example, Queensland Guidelines).

2 It is important to note however that the provision of even the most robust forensic evidence will not necessarily achieve a conviction (See Heenan & McKelvie 1996; Taylor 2001; Taylor 2004).

3 The range of physical health outcomes of sexual violence enumerated by the WHO include:
   - Homicide
   - Serious injuries, ranging from bruises and fractures to chronic disabilities.
   - Injuries during pregnancy leading to low birth weight, low maternal weight gain, infections and anaemia.
   - Injuries to children. Frequently, children are injured while trying to defend their mothers.
   - Unwanted and early pregnancy either through rape or by affecting a woman’s ability to negotiate contraceptive use.
   - In countries where abortion is illegal, expensive or difficult to obtain, women may resort to illegal abortions, at times with fatal consequences.
   - STDs including HIV/AIDS. By affecting a woman’s ability to negotiate protection leaving women vulnerable to contracting sexually transmitted diseases (STDs).
   - Women with STDs have a higher risk of complications during pregnancy, including sepsis, spontaneous abortion and premature birth. Some STDs increase a woman’s vulnerability to the HIV virus, as well. Violent sexual assault may also increase their risks because resulting tears to delicate vaginal tissue allow the virus easier entry into the bloodstream. With HIV/AIDS, the consequences are usually fatal for the woman, and possibly for her children as well.
   - Vulnerability to disease, (WHO 1997, vol. 8).

4 A summary of mental health outcomes includes:
   - depression,
   - anxiety,
   - antisocial behaviour,
   - eating disorders,
   - suicidality, suicide ideation or completion,
   - deliberate self harm,
   - sexual difficulties,
   - Post-traumatic Stress Disorder (PTSD),
   - dissociation,
   - flashbacks and nightmares
   - personal relationship difficulties,
   - compulsive behaviours,
   - panic disorder, and

5 According to the World Health Organisation’s report, Violence Against Women: A Priority Issue (1997): “At least one in five of the world’s female population has been physically or sexually abused by a man or men at some time in their life. Many, including pregnant women and young girls, are subject to severe, sustained or repeated attacks.” And Astbury (2001) notes that: “To date, research on sexual violence has been preoccupied with reliably establishing prevalence and documenting adverse health outcomes. As a result, there is now a rapidly growing body of evidence attesting to the high prevalence of sexual violence against women . . . in both developed and developing countries and the constantly expanding range of negative health consequences that can occur. Together, this data indicates a public health problem of truly huge proportions.”

6 The authors suggest the syndrome manifests itself across two distinct phases – an acute phase and the longer term process of reorganisation with a period of outward adjustment in between. The main features of the “syndrome” can be summarised as:
1 Acute Phase – occurs immediately following the assault and lasts for several weeks, resulting in the complete disruption of the survivor’s life. Reactions may include some of all of the following:

a Emotional Reactions – a woman’s immediate response to sexual assault is characterized by disbelief, shock, and a wide range of emotions. Although fear of physical injury, mutilation, and/or death is the most common emotion, she may also experience intense feelings of anger, humiliation, degradation, shame, embarrassment, self-blame, and guilt. The woman’s feelings of anger, fear, and anxiety can express themselves in crying, sobbing, smiling, shaking, restlessness, and tension, or she may hide her feelings and seem to be calm, composed, or subdued. Often this controlled response is misinterpreted as evidence that the assault did not really affect the woman or that it did not even occur. It is important not to interpret a controlled response as evidence that the assault did not really happen or that the events did not really affect the woman.

b Physical Reactions – a women’s physical reactions include soreness and bruising specific to areas where she may have been injured (throat, neck, breasts, thighs, arms, legs, or genitals); headaches, fatigue, and sleep disturbances; loss of appetite and nausea; vaginal discharge, infection, and pain associated with gynecological symptoms; and side effects from anti-pregnancy and HIV-related medication such as nausea or temporary disruptions of her menstrual cycle.

c Behavioral Reactions – a woman’s behavioral reactions may include disturbances in sleeping patterns because of nightmares; in eating patterns because of a decrease or increase in appetite, complaints of food not tasting right, or nausea; and in her ability to concentrate because she can’t block out thoughts about the sexual assault.

2 Outward Adjustment: a second phase that occurs is apparent outward adjustment as realistic problems and consequences replace the emotional turmoil created by the assault. Characteristics of this phase are that immediate anxiety subsides, the survivor returns to normal pursuits and seems to forget about the assault for a while. There is often a heavy measure of denial, suppression, or rationalization. Anger and depression may be diminished or subdued. The survivor will probably not want to talk to you about the assault during this stage. Some of the practical problems facing the survivor may include: deciding to move to a new location, and having to talk to friends, or co-workers.

3 Long-term Response: this is the sexual assault reorganisation phase, where the woman strives to come to terms with the sexual assault and incorporate it into a framework that she can understand. This phase may overlap with the first phase and continue for months or years and encompasses the survivor’s process of reorganizing her disrupted life. At this stage, the issues that come up for the survivor will be complex. A women who has been assaulted may experience some or all of the following:

a Changes in lifestyle – this may involve general upheaval in her living patterns such as curtailing normal activities or not going to work or school. She may change her place of residence or employment, or drop out of school in order to avoid being constantly reminded of the assault. She may change her phone number to give herself a feeling of safety. She may reach out in new directions for support.

b Nightmares – women report two main types of nightmares:
- flashback dreams of the actual assault in which the woman wakes up screaming or fighting.
- mastery dreams in which she gains power over the assailant or obtains revenge

c Phobias – a woman may develop fears in reaction to the circumstances of the assault. For instance, she may be afraid of being alone, or leaving the house, or of people who in some way resemble the assailant. If these fears are no acknowledged or validated, they can develop into paranoia, global anxiety, or phobias.

d Sexual Dysfunction – a woman may experience a range of reactions such as physical pain, loss of sexual pleasure, disinterest in sex, or dread of sex. Sexual activity may trigger flashbacks and feelings of vulnerability and disgust.
Compound Reactions – sometimes a woman’s reactions are compounded by problems with family, money, school or work. Sometimes she might have problems with alcohol or drug abuse.

This description has been adapted from: Sexual Assault – Victim Service Worker Handbook, Victim Assistance Program, Ministry of Attorney General, [Canada] 1993. http://www.uvss.uvic.ca/oursac/rape_trauma.htm. See also Herman 1992; Astbury 2001; and Olle 2004, Case Study Two - Adult Survivors of Childhood Sexual Assault.

7 Victims continue to identify this need for themselves. Just over three quarters (74 per cent) of victims who responded to a Victorian phone survey reported that they most needed support “at the time of the assault” while a further 15 per cent said support was critical at the point at which “they first remembered” (D’Arcy 1999: 52-53).

8 This finding relating to women between the ages of 15 and 44 years (VicHealth 2004: 25).

9 One of the many legacies left by traditional rape laws is the evidentiary burden placed on women to show they physically resisted the offender. The prioritising of forensic medical examinations in cases of recent sexual assault is as much a consequence of this historical emphasis on establishing the credibility of “real rape” victims as it is to ensure victims’ acute health care needs are appropriately met.

10 This is also true of protocols being established today. The recent National Protocol for Sexual Assault Medical Forensic Examinations for Adults and Adolescents, released by the United States Department of Justice in 2004, gives equal weight to the pursuit of criminal justice responses to the crime of sexual violence and the importance of victims receiving a health care response that is “sensitive, dignified and victim-centred” (2004: iii).

11 Carmody notes that while, “the response of individual state governments varied . . . between 1976 and 1981 Western Australia, South Australia, Victoria and New South Wales instigated public enquiries or task forces that later led to legislative reform and the establishment of sexual assault services for victims” (1992: 15).

12 These figures are quoted in the document titled “A coordinated approach to better respond to Drug-Facilitated Sexual Assault in Darwin Urban”, Women’s Health Strategy Unit, Department of Health and Community Services, Northern Territory Government, 2004.

13 Susan Brownmiller’s naming of rape as “a conscious process of intimidation by which all men keep all women in a state of fear” (1975: 15) epitomised the feminist inspired understandings of rape around this time. Sexual violence is here positioned as an expression of male power under social (and for Brownmiller biological) conditions that systematically perpetuate women’s economic, social and sexual inequality.

14 This is a completely inadequate description of the horrors endured by this woman. No re-telling can ever do justice to the pain and horror lived by a victim/survivor – especially not when the “re-telling” is third hand.

15 The Government Medical Officer (GMO) is the medical officer charged with carrying out forensic medical examinations in Queensland.

16 This response was provided by a worker as part of the small-scale background research undertaken for the ACSSA Briefing Paper, Responding to sexual assault in rural communities.

17 There are plans to implement SANE programs in Australia based on the model from the United States. However, this is occurring amidst a pool of controversy that some are seeing as more akin to a “turf war” between doctors and nurses. For example, two of the three full-time doctors employed in New South Wales to treat adult victims of sexual assault, Doctors Patricia Brennan and Maria Nittis, suggest that:

“A plan to train an initial 30 nurses to examine and take forensic samples from people who have been sexually assaulted would weigh against victims in court, because nurses have less experience in
examining women, and their testimony would be easier for defence barristers to dismiss under cross-examination than doctors.

“In a court case, ‘you’re going to want to be a doctor - it’s not what you know, it’s what you represent’, said Dr Brennan, the medical director of the sexual assault unit of South Western Sydney Area Health Service.

“But Jean Edwards, the coordinator of sexual assault medical services at Northern Sydney Health, and NSW’s only doctor dealing exclusively with sexual assault, said she supported . . . training nurses, ‘if you want people who’ve been sexually assaulted to receive a speedy service close to where they live’. Karen Willis, of the NSW Rape Crisis Centre, also supported the nurse plan. ‘Women are being compromised by having to wait’ to be examined, she said.” (Robotham 2004: 7)

There seem to be both benefits and drawbacks to the implementation of SANEs in Australia. While the literature about SANEs in the United States is resoundingly positive, a short-coming of the research has been that it is entirely generated by speaking with nursing professionals themselves. In other words, there is little research to support the notion that the experiences of victim/survivors in the care of SANEs compare far more favourably than those who have been examined by forensic practitioners.

On the other hand research into SANEs by nurse professionals is extensive and wide-ranging. The development of a professional stream undertaking specialist approaches is at least amenable to being properly scrutinised. This level of scrutiny has never been applied to physicians conducting forensic examinations in sexual assault cases. SANE nursing is relatively recent arrival to the field of professional care of sexual assault victim/survivors and is made even more visible by its contrast with the traditional forensic practitioners.

However, a concern raised by one sexual assault service provider is the potential for nurses who participate to be striving to achieve greater professional recognition at the expense of the kinds of feminist frameworks that services have fought hard to implement and maintain in terms of their approach to service delivery. The implementation of SANE programs certainly warrant close attention given they are increasingly being introduced without any consultation with local services in terms of both how the programs will be implemented and how they might relate to any existing partnerships services might have with doctors who currently perform forensic examinations.

18 The conference also declared (in part) that primary health care:

1 reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2 addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3 includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;

4 involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5 requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6 should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community (emphasis added).


The cohort for Mazza et al's survey was a Melbourne population of 3026 women attending their general practitioner for a consultation. Of these women 28 per cent had experienced some form of domestic violence in the previous year, 30 per cent had experienced “some form of sexual assault since the age of 16”, and 40 per cent of these women had experienced some form of sexual assault before they were 16 and 10 per cent had experienced childhood physical abuse.

This was most apparent in responses to the survey conducted amongst rural and regional Australia for ACSSA's third Briefing Paper (see Neame & Heenan 2004).

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