

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 women¹³ 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.

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.¹⁴ 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 GMO¹⁵ 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 SARRG’s 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).



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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