

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 healthcare 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”.<sup>2</sup>

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).<sup>3</sup> 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).<sup>4</sup>

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.