

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 unaddressed, on the wider public health of communities (WHO 1997; Astbury 2001).⁵ 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, than on their 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).

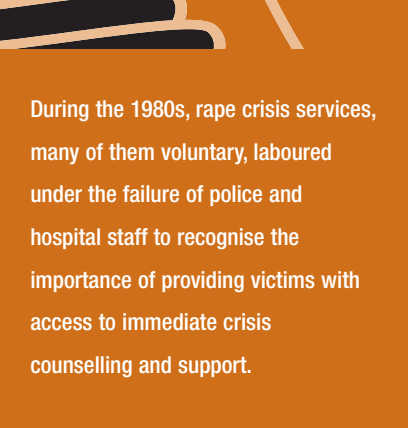
During this time, rape crisis services, many of them voluntary, laboured under the failure of police and hospital staff to recognise the importance of providing victims with access to immediate crisis counselling and support. Rape crisis counsellors were often not contacted until the victim had already 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).⁶ 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).



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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

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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).⁸ 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.