

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.

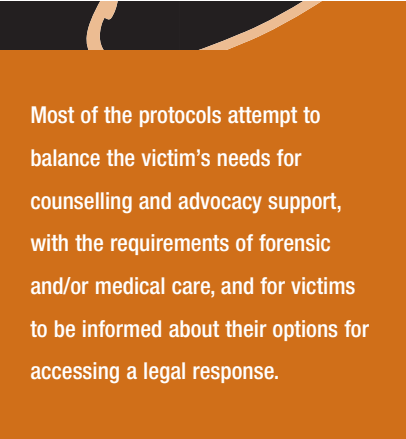
This approach takes account of:

- 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 widely¹.

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



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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.

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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