

## 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<sup>9</sup>, 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well information about the history, development or establishment of protocols had, at the time of writing this paper, been archived or recorded.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.<sup>10</sup> 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

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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)<sup>11</sup> 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).



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.

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.