

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

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: