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Good Practice in Medical Responses to Recently Reported Rape, Especially Forensic Examinations

**A Briefing paper for the Daphne Strengthening the
Linkages Project**

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Introduction

Commitment to preventing or controlling sexual violence is also reflected in an emphasis on police training and an appropriate allocation of police resources to the problem, in the priority given to investigating cases of sexual assault, and in the resources made available to support victims and provide medico-legal services. (World Health Organisation, 2002, p161)

... [the purpose is] to minimize the physical and psychological trauma to the victim and to maximize the probability of collecting and preserving physical evidence for potential use in the legal system. (Young et al, 1992)

... the best evidence which is essential to successful prosecution can only be gleaned from the best treated complainant (ie the victim). Intelligent and enlightened treatment of the complainant from the human perspective thus becomes the critical key in the success of the police function of law enforcement. (Gilmore and Pittman, 1993, p45)

The quotes above all speak to, and concur about, key issues in responses to reported rape and sexual assault: that the attention given, and resources allocated, to investigation and support reveal the commitment (at local, national and international levels) to addressing the issue; that forensic examinations are only one part of immediate health based responses; and that how women¹ are treated affects the extent and quality of evidence gathered, not to mention their willingness to cooperate with, and trust in, the legal process.

This short review takes all of these factors as starting points, in exploring current good practice in medical and forensic responses – both at the practice and organisational levels. The first part discusses what we currently know about forensic evidence and forensic practice, the second explores a number of models for service delivery.

It is beyond the scope of this overview to explore the impact of different legal systems (adversarial and investigative) in Europe on the role of forensic evidence or assess practice with respect to children. Nor is the issue of payment (for medical services, forensic examinations and reports or support services) addressed, since the variation within and between societies is considerable². It should also be noted that much of the research cited comes from English speaking countries, almost all of which have adversarial legal systems.

The role and meanings of forensic examinations

Any woman reporting recent rape to the police is likely to be taken for a forensic examination. Undergoing internal (and also external) examinations following sexual assault is a daunting prospect, and research shows they can be experienced as 'another assault' at worst, and uncomfortable and invasive at best. At the same time, a forensic examination may provide vital evidence that identifies the assailant, and/or supports the complainants account should the

¹ Whilst acknowledging that men, girls and boys also suffer sexual assault, this paper uses 'woman' to refer to complainants, since this is the primary group of service users for Rape Crisis Centres. Many of the points made about provision apply equally to these other groups, although they may have additional needs in terms of care and investigation.

² In societies where most health care is private, or covered by medical insurance, national policies need to be developed, and even legislation, which makes health providers responsible for providing care, outlines the responsibilities of health insurers and may also allocate government funds for the law enforcement elements. The overall aim should be to ensure that no victim of sexual assault is responsible for payment for any of the services they receive.

case come to court. However, there has been relatively little reassessment of the process of gathering forensic evidence in light of the recognition that most rapes are committed by known assailants, and there has been limited investment across Europe in both the training of examiners and ensuring access to the most up to date tools for gathering evidence. The fact that rape and sexual assault have become 'forgotten issues' (Kelly and Regan, 2001) is reflected in the limited development of responses, whether based in the health, criminal justice or NGO sectors.

Canadian research suggests that forensic evidence increases the likelihood of legal action against perpetrators (McGregor et al, 1999) and one US study found that just having the forensic examination doubled the likelihood of a prosecution (Lindsay, 1998); although only documented severe injury appears to predict a conviction (Du Mont and Myhr, 2000). From a criminal justice perspective lack of consistency in how evidence is collected and recorded, and failure to link examinations to the facts of the case have been noted as problematic areas in the UK (HMCPSI, 2002).

Hazelwood and Burgess (1995) identify five key elements in health responses to recent rape and sexual assault:

- treatment and documentation of injuries;
- collection of medico-legal evidence and maintaining chain of evidence;
- treatment and evaluation of STIs;
- pregnancy risk evaluation and prevention;
- crisis intervention and arrangement of follow up counselling (p267).

Forensic examinations are, therefore, only one element in medical responses: many women also seek reassurance about, and in some cases need treatment of, injuries³, alongside information about and tests for pregnancy and sexual infections. An estimate from the USA, based on figures for "probability of pregnancy resulting from a single act of intercourse on a random cycle day", suggests that 4.7% of rapes would result in pregnancy (Stewart and Trussell, 2000), and a study of the incidence found an actual rate of 5% (Holmes et al, 1996). Rates are considerably higher if the assault occurs close to ovulation, and in countries where regular contraceptive use is low. The potential for pregnancy should, therefore, always be investigated, and some commentators recommend automatic emergency contraception for any woman reporting within 72 hours and who has a negative pregnancy test (Stewart and Trussell, 2000). Research findings on the rate of sexual infection following sexual assault are not robust, but rates are low in developed countries, with HIV infection the lowest (0.1-0.2% for vaginal rape and 1-2% for anal rape). Practice varies internationally as to whether automatic HIV screening is part of the medical protocol, and on whether prophylactics are automatically prescribed. The current recommendation is that medication should be given where it is known/suspected that the perpetrator is HIV positive, and to be effective prescribing needs to begin within 72 hours of the assault. A key global issue has become affordability, for poorer countries in which the rates of HIV infection in the general population are high. Rape Crisis Centres, for example, Capetown Rape Crisis in South Africa, have campaigned, and even taken legal action, to establish a right for this treatment.

The decision to report rape is a complex one, which women take weighing factors such as their own circumstances (including cultural issues), their expectations (or not) of just and fair

³ Data from the US National Crime Victimization Survey data 1992-2000 (Rennison, 2002) reveal that over a third (39%) of rapes and attempted rapes involve injury in addition to the sexual assault and 17 per cent of sexual assaults result in injuries; a minority of the injuries are classified as 'serious'.

treatment from practitioners. Reporting, however, does not just mean involvement with the criminal justice system, research from North America shows that those who report rape are much more likely to access health care and support in the aftermath - over half of those who report accessed medical treatment, compared to under a fifth of those who choose not to report (Rennison, 2002; Resnick et al, 2000): reporting, therefore, acts as a gateway to a range of other services.

There are also implications beyond immediate crisis intervention, since a quarter of adult rape victims⁴ experience severe and long-term impacts (Hanson, 1990)⁵. Repeated abuse - which often occurs, but is seldom recognised⁶ - exacerbates impacts and Judith Herman (1992) has proposed the concept of 'complex post-traumatic stress disorder' to address the cumulative consequences of repeat victimisation. Several projects document increased use of medical care in the two years following a sexual assault (see, for example, Koss et al, 1991), with rape victims the most frequent users. However, routine screening in health settings is limited, including in mental health (op cit). A number of studies on routine screening for domestic violence, which has been more strongly promoted, conclude that even where protocols exist, the majority of health professionals fail to ask the questions, or develop personal systems of discretion (Kelly, forthcoming).

It is vital, therefore, for both the complainant and criminal justice system that access to, and practice within, the health sector combines availability, sensitivity, awareness and professional standards. Medical examiners need to be aware of the meaning of both rape and forensic examinations for victims/survivors, that they are likely to be feeling dirty, ashamed, vulnerable and extremely sensitive to any implication that they are not telling the truth. They also need to be aware of the legal context in which they are gathering evidence and - as later sections will demonstrate - need the skills, experience and technical resources to adapt the process to the specifics of each case. Even in consent cases the accused may deny some elements of the victim's account: it is vital, therefore, that examiners endeavour to document all evidence which might support the women's story.

Building good practice in forensic examination

Forensic examinations have some unique features, such as a medical practitioner acting as an agent of law enforcement; and a dual purpose - to address the immediate needs and concerns of the woman and the justice system's needs for rigorous evidence collection. Good practice involves understanding this dual function, and recognising that whilst they can often be combined relatively seamlessly, there may be conflicts for the complainant and/or the medical examiner (Du Mont and Parnis, in press). The box below summarises the victim and justice needs involved.

⁴ The term 'victim' is used in places in this paper, as is the term 'complainant'. This reflects two issues: firstly, the focus of the paper is recent rape and forensic examinations - in both contexts the term victim is appropriate - the woman has been recently victimised and she has the status of victim/complainant within the legal system; secondly, it is part of an attempt to reclaim the word, in limited contexts, for feminist analysis, both because it is meaningful to many women themselves and to imbue it with more complex meaning (Kelly, 2001).

⁵ Some practitioners use a specific diagnosis of Rape Related Post-Traumatic Stress Disorder (RR-PTSD), whilst others, especially in Western Europe, prefer to work with a more open trauma framework (Rothschild, 2000).

⁶ Rape tends to be understood as a 'one off' event, but the prevalence of known perpetrators and overlaps with child sexual abuse and domestic violence mean that this conception is inaccurate. The Canadian Violence Against Women Survey, for example, found that of the one in three women reporting sexual assault, 60% said it occurred on more than occasion.

Victim needs	Justice system needs
Treatment of injuries	Accurate history of assault
Prompt examination	Documentation of physical findings
Crisis intervention and support	Collection and preservation of evidence
Prevention of STIs	Interpretation of findings
Assessment and prevention of pregnancy	Presentation of findings and providing expert opinion in legal proceedings

Internationally current opinion is that full examinations can provide relevant evidence up to 72 hours after the assault, and can be useful after this time frame if: the woman is bleeding/in pain and/or was subjected to serious levels of physical violence. The rapid developments in forensic science, and the use of DNA tests to detect serial offenders, lead some commentators in the US to suggest that in all sexual offences examiners should endeavour to gather as much evidence as possible if the assault took place relatively recently (Dept of Justice, 2003).

An approach to forensic examinations which places the rights and dignity of the victim at the centre will include the following aspects:

- that complainants are accorded priority;
- injuries are assessed immediately, and where necessary treated;
- the examination is conducted in private, in a facility that offers some level of security, is open 24 hours a day and where there is access to medical services;
- examiners are skilled not just in the collection of evidence, but also in understanding the meaning of sexual assault, and how to adapt the procedures to the facts of a case and the local legal context;
- any additional needs (such as interpreting or communication) are addressed;
- the process is understood as a fluid and interactive one;
- informed consent is sought at the outset⁷, and for each procedure;
- offering as much control to the woman throughout;
- integration, as far as possible, of medical and forensic procedures;
- following the examination providing facilities to wash, change clothes, have a drink and make phone calls;
- discussion of safety planning before discharge;
- routine mechanisms for follow up and advocacy.

A forensic examination is a detailed and meticulous external and internal examination to document injuries and other evidence. Forensic evidence includes any combination of the following: hair; seminal fluid; saliva; blood; urine and non-biological evidence, such as clothing, traces of soil, grit etc. Each type of evidence has a specific relevance within the context of the assault in question. In order to conduct an examination effectively, therefore, the examiner needs an accurate account of the attack and the circumstances it took place in: this might be provided by a police officer, or the complainant herself. Recommended good practice in some parts of North America now involves the initial statement being taken in a context where the police, medical examiner and victim advocate are all present, thus decreasing the need to have to repeat the account.

⁷ Obtaining this requires a process before examination in which the purpose and procedures are explained, the extent of confidentiality and the options women have outlined. Depending on the local procedure, this might include the right to have the examination and evidence stored before making a report to the police, and the right to refuse certain procedures and/or to discontinue the examination at any point.

Some aspects of medical and other history are also taken at this point, referred to as a 'forensic medical history' which ensure that any pre-existing conditions which might affect interpretation (scars from surgery, prescribed drugs) are known about, as well as any findings which might confound those related to the assault (such as having had consensual sex in the previous few days) accounted for. A full medical history should not, however, be taken as part of the forensic examination, especially in countries with adversarial legal systems. Details recorded on the examination form, such as previous abortions, previous sexual assaults or number of sexual partners have provided a 'back door' route to evade the legal restrictions on sexual history evidence; since such forms are the evidential record, and in adversarial systems disclosable to the defence. Good practice here, therefore, separates the information needed for forensic examinations (and most importantly recorded on forms) and that gathered for health and medical screening purposes.

These processes should ensure that the examiner has the following knowledge, which will in turn guide their search for evidence: the date and time of the assault/s; where it took place and who the assailant was; pertinent recent medical history, including last prior consensual sex and stage of menstrual cycle; the sexual acts involved; the nature of force and threats used; whether there is loss of memory, or was loss of consciousness; whether ejaculation took place and where; whether a condom and/or lubricant was used; any alcohol or drugs consumed during the last 12 hours; actions taken since the assault, such as washing, drinking, smoking.

The physical examination begins with careful examination of clothing, which is often removed whilst the woman stands on piece of collection paper. A Woods Lamp may be used at this point, the ultra-violet light enables identification of stains. Clothing should only be sent for forensic testing if it is likely to have evidential value⁸. Collection paper will also be used for the initial external examination, where any debris on the skin and hair combings from the head and pubic area are undertaken (in some jurisdictions the woman is allowed to do these procedures herself). Careful documentation of visible injuries such as bruising, scratches and bite marks is a vital component, and some argue the most important given a) the increase in consent defences and b) the suggestion that evidence of injury is most strongly associated with prosecution and conviction. All such injuries should be described, documented on body charts and photographed (see later section on photography). Whilst research evidence is limited, some studies suggest a number of key sites where injuries are most likely to be found (thighs, neck, arms and face), and a correspondence between external and internal injuries (Lindsay, 1998). Swabs will also be taken if there is a likelihood of saliva or semen being found on outer body surfaces. Emerging good practice suggests (US Department of Justice, 2003) that follow up examinations should be considered, especially where the initial exam is soon after the assault, to document bruising which emerges later, they can also be used to document healing of internal injuries.

The next stage is the external and internal genital examination which involves looking for injuries or other findings (in the case of girls a broken hymen, or forms of reddening and/or tenderness of the skin/tissue) as well as collecting samples which might document the presence of sperm (these may also be taken from the mouth, and other parts of the body depending on what form the assault/s took). Best practice here used to involve using an

⁸ Major clothing items such as coats and shoes may need to be replaced for complainants, since they may be the only such items they own.

external light source to enable clearer visualisation⁹. More recently colposcopes, anascopes and medscopes are preferred, but many examiners lack both training in, and access to the instruments. A colposcope is a small external instrument that is used to both provide a light source and magnify tissue, enhancing identification of micro injuries. An anascope performs similar functions in anal examinations. Medscopes are smaller, less expensive instruments often used by dentists. All of these instruments can be easily connected to cameras making recording internal injuries on still photographs or video possible.

The increasing incidence of drug-assisted rape has led to the need for complex blood screening tests. However, the ability of forensic laboratories to do these, and the limited sensitivity of the tests themselves, mean that strong positive findings are limited to certain drugs and samples that have been taken within 12-24 hours of the assault. This emphasises the importance of women (or police through early evidence kits) collecting their first urine sample.

In terms of investigative needs, the examiner and police should confer after the examination is complete (preferably when the complainant is with an advocate, who is explaining the next steps) to clarify any discrepancies and for the examiner to alert the police to additional samples that ought to be explored at the crime scene (for example, a used condom, fibres/gravel/soil etc which might match those found on the complainants clothing, and staining on bed linen or furniture).

Current and ongoing debates and concerns

There are also a number of contentious issues (see also, Dept of Justice, 2003; Young et al, 1992), which continue to be debated in the field about best practice.

Forensic science services

A proportion of the evidence gathered needs to be submitted to forensic science laboratories in order for the more complex tests - such as DNA - to be undertaken. Delays in the response are common complaints. Currently in the USA there is estimated to be over 200,000 'rape kits' that have not been analysed (Department of Justice, 2003). One recent commentary noted that despite the publicity given to DNA data banks¹⁰, such evidence is only submitted by the FBI in 10% of sexual assault cases, the authors note "little is recovered from crime scenes, less is submitted to crime labs and still less is analysed" (Weeden and Hicks, 1997, p17)

Forensic scientists also note that they are often sent vague instructions to conduct all tests on all samples, which is wasteful of their time and resources. Suggestions for improving practice here are the development of forms which are much more specific about what tests are being requested and why, and which contain a brief description of the facts of the case. Those submitting the requests will also be asked to prioritise the tasks in terms of the history of the assault and their current investigative needs.

⁹ Some jurisdictions have also used Touladine (blue) dye, although there is some disagreement about its use (Dept of Justice, 2003).

¹⁰ The ability of such databases to detect, and even identify, serial offenders is seriously compromised by failures to collect, submit and analyse material. There potential is illustrated by a study undertaken by Anne Burgess and colleagues: 41 serial offenders admitted to a total of 837 rapes and 401 attempts. Most also reported that their earliest victims were younger siblings, girlfriends, spouses and other known women (cited in Dept of Justice, 2003)

Hair evidence

Significant transfers of hair from perpetrator to victim occur in 4% of cases. Forensic experts agree that combing for foreign hairs and pulling hair of the victim is the best comparative method. Routine pulling of pubic and head hair has, however, been questioned as insensitive and even unnecessary. However, cutting hair is not an alternative, since it lacks the root where the best DNA can be found. Given a) the increase in DNA technology and specialisation¹¹ and b) the limited number of cases where hair samples are evidential, a number of experts question routine hair pulling. Recommended good practice is to comb for hairs that do not belong to the victim, and loose hairs of their own, and only where necessary, at a future date, to take additional hairs from the victim (Archambault, 2002).

Spermatozoa and Seminal Plasma

'Semen evidence can play a central role in corroborating a victim's story and in identifying the assailant' (Young et al, 1992, p880). Historically the presence of semen has been seen as important evidentially: it can show sex took place; can give an indication of timing and more recently has become a source for DNA profiling. Sperm was found in 46% of a sample of 5743 women in USA (Committee of the Judiciary, 1991). It is also now possible to detect seminal plasma, even where no actual sperm is found (the case for men who have had vasectomies, are alcoholic or a number of other conditions) and even that identify use of a condom. Some problems have been identified where these tests are done as an initial screen by emergency room staff using 'wet preps' (slides that are examined under a microscope. Some US commentators note that police have a tendency to drop/not pursue cases where no evidence of sperm is found (Young et al, 1992). Also initial emergency room testimony may conflict with those of a forensic scientist, since few health care providers have skill in this area outside the specialism of infertility treatment. Immediate findings are not, therefore, recommended, but rather good practice involves careful collection and preservation of samples by a forensic examiner, which are then sent for analysis to a forensic science laboratory. There has also been a shift to greater use of DNA tests in the US as the increase in men with vasectomies decreases sperm evidence.

Medscope or Colposcope?

There is a debate currently in the US (Little, 2001) is about whether a medscope (adapted from dental practice) might be a more useful tool. Its advantages are thought to be: it has greater depth of field; can be used to document injuries on other parts of the body; is less expensive; is portable and easier to operate. With a medscope photographs are taken using a foot pedal, which frees the hands of examiner and decreases risks of contamination. It is also possible to view the image on a monitor to ensure is well focused. At the same time technology is increasing the range of the colposcope: specially designed forensic models, with advanced digital imaging systems, and specially designed software ensure "the highest quality of photo documentation, evidence preservation and the usefulness of the images for trial" (Little, 2001, p13).

¹¹ In at least one area of the USA there are no longer microscopic hair specialists, since DNA has become the predominant evidential route to identification of a person.

Photography

How injuries should be photographed, and access to the images are both unresolved issue, with Polaroid and 35mm cameras being recommended. The advantage of Polaroids is that they are immediate and available to law enforcement at the earliest opportunity, the disadvantage is that they are less sharp for close ups, although new cameras have improved facilities. All Polaroid photos should be marked on the back with the case number and the date. Other complications arise with respect to digital photography, given the possibility of altering them with computer software. One suggestion is to use a combination, although Polaroids are not possible for internal injuries.

Practice has suggested that the first photograph should be of the victims face, and then others follow in a systematic order. A useful alternative is to take a picture initially of a sheet of paper with the case number and date and to end each roll of film with the same identifier. Also using cameras where there is a facility to date mark adds to the evidential record.

Who should have access to photographs, and where they should be held is another contentious issue, and has become more pronounced with respect to images of internal examinations/injuries - many complainants do not want public disclosure of these materials. This, in turn, raises the issue whether still and video photography through colposcopy should be presented as routine element of the examination, as seems to be the case in the USA, or an optional 'extra' as is currently the case in the UK. One safeguard currently used in parts of the US is to use two rolls of film/memory cards, with one recording internal, and the other external, injuries, alongside a practice of not routinely printing or producing internal images. In some places there is a local agreement that the photographs remain within the hospital/sexual assault centre, and are only made available to other medical experts.

The evidential value of forensic medicals

Whilst for children a forensic examination can establish that a sexual assault has taken place, since consent is not an issue, this is not the case for adults (or adolescents). Where the assault is by a stranger, there is a small chance that DNA evidence may identify them, and where the accused denies sexual contact the same evidence may prove that it took place. In most cases, however, the defence is likely to be one of consent and all forensic evidence can do here is support, but not prove, the account of the complainant.

There are four purposes of collecting forensic evidence:

- to identify the assailant (blood, saliva, semen, skin cells can all be tested for DNA) ;
- to confirm recent sexual contact (injuries/soreness around the genital area; seminal fluid, saliva and internal injuries)
- to establish force¹² (documentation of internal and external injuries, torn/soiled clothing, positive toxicology tests);
- to corroborate the victim's account (are findings consistent with it).

There is little agreement in the literature about the percentage of rape cases in which external and/or internal injuries are documented: one explanation for this divergence may be the time frames of the studies and technological differences in examination methods. Studies which

¹² This is especially important where the legal definition of rape is based on force.

suggest findings occur in a minority of cases tend to be have been published pre-1995, and less likely, therefore, to have involved instruments such as colposcopes. More recent case series from North American programmes using both colposcopes and forensic nurse examiners report documented findings in the majority of cases where forensic examinations were undertaken. For example, in 123 cases examined in Ohio, only 19 per cent involved no external or internal injury (Dandino-Abbott, 1999) and McGregor et al (2002) report that in cases seen between 1993-1997 in a hospital based Sexual Assault Centre in Canada some physical injury was documented in 88 per cent, genital injury in 42 per cent and positive forensic results found in 38 per cent. Sommers et al (2002) shed further light on the role of colposcopes in the documentation of genital injury; based on a sample of 576 cases (200 of which used a colposcope) just using the eye produced positive findings in 32 per cent of cases, whereas use of the instrument increased positive findings to 87 per cent. These researchers also compared findings from internal examinations following consensual heterosexual sex and rape: the former produced genital injury findings in 10 per cent of cases compared to 42 per cent for the assault cases.

Forensic reports should be clear and consistent, noting all findings that support the account of the complainant. Medical examiners should also always explicitly note and explain that the absence of certain findings - sperm, injuries - do not mean that no assault took place. Reports - both initial for police, and those submitted to court - would be enhanced by reference to research that supports such statements.

Good practice in service delivery

There have been a number of problems identified with the process and procedures surrounding forensic examinations:

- low priority where reporting is through hospital emergency rooms;
- poor availability of forensic examiners - both access to female examiners and to anyone during daytime hours;
- limited training, expertise and sensitivity amongst forensic examiners;
- lack of privacy and poor environments in locations where examinations are conducted;
- limited equipping of facilities;
- absence of national minimal standards;
- reluctance of (or delays in) examiners to provide reports/give expert testimony in court;
- limiting access to those who have already made an official report to the police.

Studies on reporting rape offer crucial insights into what makes the experience of a forensic examination less traumatic. These include: a female examiner; privacy; a non-institutional setting; being talked through the process; a caring but professional manner (Kelly, 2002). Negative experiences are associated with: long waits; no choice about the sex of the examiner; the examiner appearing to disbelieve; and 'heavy handed' examination (Jordan, 2001; Temkin, 1996).

Many jurisdictions have developed versions of Rape Examination Kits, which contain all the necessary resources for forensic examiners to conduct the examination, collect samples and record findings (on body charts and in some cases a report form). A series of studies in Canada, drawing on samples from two hospital based programmes, raise profound questions about practice which uses a single protocol for all forensic examinations. The work of Janice Du Mont, Margaret McGregor and colleagues has shown that a 'one size fits all' rape examination kit and protocol fails to reflect the different evidential issues likely to be at stake when the rapist is a stranger or known (Du Mont, J, McGregor, M, Myhr, T & Miller, K, 1999;

Du Mont, J & Myhr, T, 2000; McGregor, M, DuMont, J, Myhr, T, 2002; Parnis, D and Du Mont, J, 2002). Using complex statistical tests on several different data sets they have also demonstrated that, at the statistical level, the only medical evidence that predicted either charges or conviction was documented injury. They note, however, that further qualitative studies are needed to assess how forensic evidence is used in the decision-making processes of police and prosecutors: we do know from the UK and other jurisdictions that refusal to have a forensic examination is often a factor in cases not being proceeded with (Kelly, 2002). Whatever the outcome of such studies, the Canadian research raises a number of critical issues: the importance of documenting external injuries; that protocols should be created on the basis of the type of sexual assault (Du Mont, J & Parnis, D, 2001); that health professionals should reflect on the relative weight accorded to forensic evidence and health care, in their responses to rape and sexual assault (Du Mont, J & Parnis, D, 2000); and the continued influence of the concept of 'real rape'¹³ in the legal arena (Du Mont et al, in press; Kelly, 2002).

Models of provision

The questions about how a forensic examination should be conducted are linked to a further series about who should conduct them and where. Given that examinations have to be conducted by medically trained staff, the need for sterile conditions to ensure no contamination of evidence, the importance of access to medical care, and the need for a 24/7 service, hospital settings are the most suited, although this may not be possible in rural and sparsely populated areas. Emergency departments are the most likely site to encounter recent sexual assault victims, the key questions are whether they provide a comprehensive service and work in partnership with other providers.

The realities of sexual assault, and its immediate impacts, make the environment in which examinations take place critical. A private, dedicated space, which combines clinical needs for cleanliness in the examination room with a separate calming and relaxing location to undertake interviews and support, are minimum requirements.

The previous discussion suggests the following issues are critical in ensuring that forensic examinations maximise the evidential potential and provide comfort, reassurance and necessary health input to complainants.

- ✓ Speedy response
- ✓ Avoiding the triage system in hospital A&E departments
- ✓ A private, dedicated space
- ✓ A well equipped examination room
- ✓ Trained and skilled practitioners
- ✓ Female examiners
- ✓ A streamlined victim-centred information gathering process
- ✓ Time to move at the speed the victim/survivor is comfortable with
- ✓ Protocols and evidence kits which are applied flexibly, according to the facts of the case
- ✓ Space to discuss the process, debrief and undertake crisis intervention
- ✓ Provision of, or links to, medical follow up and advocacy/support services

Many of these requirements are obvious, others less so.

¹³ This refers to perceptions that still define rape in terms of a stranger attack, involving a weapon, taking place outside and resulting in injuries.

All studies that ask, find that both women and men reporting sexual assault express a preference for a female forensic examiner (Kelly, 2002). A full forensic examination is time consuming, often lasting more than two hours, requiring significant time out of other duties when conducted by doctors, either hospital based or family doctors. It is the limited availability of forensic examiners that results in delays. A speedy response is vital, both to provide reassurance and comfort and for evidential purposes. For example, it is preferable that victims/survivors of sexual assault do not drink, eat, go to the toilet or shower before the examination, as such activities may remove or affect evidential findings. Having to wait for hours, under such restrictions, is not only unpleasant, but can become a deterrent to continuing with the case¹⁴. Whilst protocols and examination kits are critical elements in ensuring basic standards are upheld, a recent UK audit of police and prosecutor practice (HMCPSP, 2002) and Canadian research (Parnis & Du Mont, 2002) make clear that their use needs to be adapted to the facts of the case. This in turn suggests a need for skilled practitioners, who understand the relevance of evidence to legal processes.

A recent review of models of provision (Kelly, forthcoming) revealed that whilst in some countries a single model of provision predominates, in the majority there are a range of models, as well as less organised forms of provision, operating simultaneously. For most rape survivors, therefore, the responses they encounter depend not only on which country they live in, but also *where* they live within the country. This geographical 'lottery' is reflected in wider responses to gender violence (see, for example, Kelly 1999 with reference to domestic violence), with some fortunate to be located in areas where best practice and co-ordination are relatively well-developed, but most encountering less services overall, and inconsistent practice. In the next section a number of good practice models are outlined.

Models of good practice in service provision

Five ways of organising medical and forensic responses are described (for more detailed discussion see Kelly, forthcoming): two relate to ensuring skilled professionals undertake examinations - co-ordination of doctors and forensic nursing; three are broader models of provision - Sexual Assault Centres; Centres of Excellence and Integrated Models.

Trained doctors in a co-ordinated scheme

This is probably one of the most common models, within which doctors are recruited by law enforcement agencies, provided with training, and then become part of local rotas. Often these are generic forensic examiners, who therefore have limited knowledge with respect to sexual assault, and recruits tend to be male. A number of countries have developed schemes that enable them to recruit more women and to specialise in examining adults and children in sexual offence cases.

The limitations of such schemes include: no dedicated location for conducting examinations; limited availability of doctors, especially during the day time; relatively low development of expertise, since examiners may only undertake a few examinations each year; limited co-ordination and integration across the agencies involved; poor links with follow up services; absence of integrated crisis intervention and advocacy.

¹⁴ A current experiment with an 'early evidence kit' in the Metropolitan police, London, UK involves police officers taking mouth swabs and urine samples, which then permit greater levels of comfort.

Forensic nursing

Forensic nursing is the application of nursing science to public and legal proceedings - combining forensic science with the treatment of trauma. A forensic nurse is expected to provide direct services to patients/service users, professional consultation and services for police and the legal system. A range of specialisations have developed¹⁵, one of which is termed in the US Sexual Assault Nurse Examiner (SANE¹⁶). Forensic nurse examiners now conduct the majority of sexual assault forensic examinations in the USA, and are also strongly established within Canada. A pilot has just been completed in the UK¹⁷. There is a growing literature documenting forensic nursing and a professional organisation (see, for example, www.forensicnurse.org). There is no doubt that in the USA the nurses have a longer and more in depth training than most forensic doctors, and the organisation of schemes recommends that a minimum of ten examinations per year to maintain expertise. Forensic nurses have also been at the forefront in integrating use of colposcopes.

In North America most forensic nurse models are hospital based, although the New York framework is a rape crisis facility within the Victims Assistance Agency (NYC Alliance, 2001a, 2001b). Community locations are seen to offer even more privacy, and often encompass a more comprehensive service (follow up and counselling) – the challenge in these settings is to meet clinical standards. There have also been important developments in adapting models to rural and remote regions. Whilst their area of expertise began in adult rape, forensic nursing has now expanded to encompass child sexual abuse, and more recently domestic violence¹⁸. Various models of service provision exist, currently most provide an integrated forensic service, and many are part of multi-disciplinary Sexual Assault Response Teams (SARTS). Many schemes have direct partnerships with victim advocacy schemes (some of which are provided by rape crisis centres) and community services, and where this is not the case forensic nurses are expected to have up to date knowledge of local support services and provide referral advice and information.

Some of the advantages of forensic nursing are: it increases the likelihood of being able to provide a female examiner; examiners are frequently highly skilled and specialised; well organised schemes ensure prompt availability; schemes can be designed so that the provision of a report and giving evidence in court are considered core elements, rather than 'extras'¹⁹; provision can be less expensive than that involving doctors; and organised forensic nurses have become strong advocates for not just ensuring minimum standards, but building concepts of respect, privacy and dignity into service provision.

Sexual Assault Centres

There are a number of models of Sexual Assault Centre (SAC), with many countries having hospital based provision, and Australia also having a community based option, but close to a partner hospital. SACs have been one response to criticisms of existing provision by women's groups and survivors, as well as recognition of the gaps in investigation by agencies, such as

¹⁵ For example, Nurse Coroner/Death Investigator, Forensic Psychiatric Nurse; Forensic gerontology specialist.

¹⁶ Concerns have been raised about this designation, following challenges in legal proceedings that argued it presumed a finding of sexual assault, some, therefore prefer the designation Forensic Nurse Examiner (FNE).

¹⁷ At the St Mary's Sexual Assault Referral Centre, St Mary's Hospital, Manchester.

¹⁸ The international Association of Forensic Nursing (IAFN) has just published guidelines for Domestic Violence Nurse Examiners

¹⁹ This is an important factor in countries where much health provision has to be paid for, often by the patient, and addresses complaints from police and prosecutors in some jurisdictions that the failure of doctors to submit reports and/or their reluctance to provide expert testimony in court makes prosecution difficult, if not impossible.

the police. Some countries, such as Canada, have extensive networks (although uneven across the states), others such as Germany, Switzerland and the UK have a number of centres - often in major cities or locations where either women's groups or committed medical staff have campaigned to improve local provision.

SACs aim to provide a high standard of comprehensive care to anyone who has experienced recent sexual assault. In Canada their mandate is "*to attend to the medical, emotional, social and medico-legal needs of clients in a prompt, professional, and compassionate manner and to provide leadership in the prevention of sexual assault*" (Du Mont and Parnis, 2002). This broader framework (in contrast to a more limited medico-legal model) is attributed to their foundation on a feminist perspective which emphasised the importance of choice, respect, empowerment and honouring differences, alongside linking crisis intervention, longer term support and prevention. Privacy and confidentiality are also key principles in service delivery.

SACs tend to be limited to recent sexual assaults, ie within the last two weeks, and are available to women, men and children²⁰. Access is usually through the hospital emergency room, where any necessary emergency medical care will be undertaken. Where this is not required the SAC itself is invariably a private suite of rooms, one of which is equipped for forensic examinations. Some SACs are limited to two rooms - one for examination and another for support/follow-up and a shower room; others have more extensive provision; still others have the two rooms plus shower (often close to the Emergency Department) and an additional suite located elsewhere in the hospital where any follow up and counselling takes place. Where these services are not provided by SACs, they tend to have strong links with other agencies who they refer on to. In North America there is often a strong victim advocacy programme which may be based in the prosecutors office, or even rape crisis centres, and the advocates are expected to link in at the earliest point, ie when someone first attend a SAC.

SACs place emphasis on choice and options, meaning that a staff member will be allocated to explain the procedures and the options; many SACs offer services regardless of whether a report will be made to the police, and offer the possibility of taking samples, and having them stored for a period of time, so that the decision about reporting can be taken at a later date. A number of SACs, especially in Canada, have integrated pro-active follow up within the week of attendance²¹. Funding of SACs varies, with some in North America being supported through federal or state funding for victim services or health care budgets. In the UK funding for staff and services has come from police budgets, with health covering the accommodation costs.

The Australian model (termed Sexual Assault Services, SAS) emphasises longer-term continuity of care and advocacy, rather than crisis intervention and forensic examination, and have developed national standards (National Association of Services Against Sexual Violence, 1998). All SASs have direct links with a hospital for the provision of medical care and forensic examinations, and in some cases these are conducted within SAS premises; although delays in accessing doctors, especially during the day are common, and few services can guarantee a female examiner. This model represents health funded and supported agencies that do not have to adapt their service provision to a hospital disease and crisis intervention framework,

²⁰ In contrast to Rape Crisis Centres, who often are women only, and whose most frequent users are women dealing the legacies of assaults that happened some time previously.

²¹ St Mary's in Manchester UK have piloted this approach, and initial evaluation findings demonstrate that service users not only support, but also appreciate this innovation, challenging the long held orthodoxy that violence against women services should be re-active, only responding to contacts made by women themselves (see also Burton, Regan and Kelly, 1998 whith respect to domestic violence).

nor do they have to function within the bureaucratic rules of a large institution. They have much in common with well-funded rape crisis centres, undertaking a lot of longer term support of adult survivors of child sexual abuse²². The community location means that some services are for women only, but a number also work with men and children: services for men may have separate locations and their own staff, but are institutionally linked to the women's service, whereas others are co-located. One advantage stressed by services is that their location permits self-referral, with no requirement of either recent assault, or involvement with the police. The emphasis on support and care post-assault perhaps accounts for the limited work undertaken developing forensic skills, and the absence of forensic nursing in Australia.

Centres of Excellence

This model seems common in Scandinavia, with centres reported in: Copenhagen; Oslo; Reykjavik and Uppsala - and has been described as the 'Nordic model of rape victim centres'. However, similar provision also exists in Amman, Jordan and Dublin, Ireland to name but two. Centres of Excellence are always hospital based, and often develop through the vision and leadership of a committed woman doctor. They represent a national resource, usually, but not always, located in the capital city. What distinguishes a Centre of Excellence is that they are usually well funded, recognised nationally (and often internationally) as holding extensive expertise, and invariably undertake research and publish findings in medical and other journals. Whilst some attend to children and adults - most are limited to adult sexual assault; some are limited to cases reported to the police, others have an open self-referral policy. Such centres specialise in the emergency response to recent rape and sexual assault. Their core services, therefore, tend to encompass: emergency medical treatment/care; forensic examination, often using the latest equipment and informed by research; and crisis counselling. Several examples also provide longer term support, and some level of advocacy. There tend to be very strong links with other agencies, especially the police and prosecutors. Their role is to be an example of best practice, continually updating knowledge and skills, in the light of their own and the wider international knowledge base.

Whilst those who attend such centres will be seen by skilled and experienced staff, there are a number of disadvantages for those outside the catchment area. Resources tend to be drawn to the centre, with limited development and provision elsewhere; indeed it could be argued that the level of service is so far above that possible elsewhere that it acts as a disincentive. For countries with relatively small populations *and* landmass, these limitations are less pronounced.

Integrated Responses

Whilst particular implementations of the models outlined above have aspects of integration - either providing services to adults and children, or covering a range of forms of violence against women - these are matters of local implementation. Integrated models refers to provision that has one or both of these features as an organisational principle. Interestingly, this kind of response is much more common in developing countries. Possible explanations for this include: the need to maximise scarce resources; learning lessons from other countries; less time and opportunity for 'turf' issues to develop; and a stronger connection between women's NGOs and policy makers in the development of health based responses. The most well known

²² Although recent changes in funding regimes have decreased services to this group in some states.

and promoted example is the 'One Stop' model developed in Malaysia²³, which is currently being replicated in much of Asia.

Integrated models can be both cost effective and responsive to the needs of service users. Many practitioners support such integration, even where their particular service did not operate in this way: recognising the connections between forms of violence at both the conceptual level and in the lives of women and girls. One potential tension here with respect to domestic violence, might be a shift to an evidence gathering, rather than safety planning, orientation. Such wider integration would, therefore, need to ensure that support and advocacy elements were prioritised. But this need not be considered a problem, since there is strong evidence that advocacy, rather than counselling, is the primary need in the immediate and short-term aftermath of sexual assault, especially where there has been an official report to the police. The needs of survivors of rape, sexual assault and domestic violence may turn out to be more similar than different, if we approach this with an open mind. The emergence of integrated models in developing countries, and the expansion of specialist sexual assault services to encompass domestic violence in some developed countries, offer further support for this view.

Developing Minimum Standards

All the models outlined above have a number of core elements which must, therefore, be considered basic requirements for any health based response to sexual assault.

- Privacy through the development of dedicated rooms, or a centre.
- Philosophical principles underpinning practice that emphasise respect, dignity, rights and choice.
- Enhancing forensic practice through capacity building – both the number of trained examiners (often through involving nurses) and their skills base.
- Access to female examiners.
- Ensuring that even if people have to wait for a medical practitioner, that a staff member is available to greet them, take them to the more private rooms, and explain their rights and what may happen next.
- Linking provision of immediate medical care, forensic examinations, crisis and short term counselling, follow up medical care and advocacy.
- Combining service provision with training, awareness raising and system advocacy.
- Leadership within the service, and some form of community accountability.
- Ensuring access is as wide as possible, and that outreach efforts are targeted at under-served populations.

The National Advisory Council on Violence Against Women and the Violence Against Women Office in the USA have produced an extremely useful *Toolkit* (2001). Chapter 2 is devoted to the health sector and recommends series of actions if gender violence is to be responded to in a holistic and comprehensive way (those marked ✓); these have been supplemented by additional issues from the literature (those marked ✱).

- ✓ Increase understanding of violence against women as a crucial public health problem.
- ✓ Improve standards of clinical care.

²³ One inspiration for this model was a study visit to the UK funded by the British Council, which included visiting the St Mary's Sexual Assault Centre.

- ✓ Educate all health providers using a combination of a professional training curriculum and continuing education.
- ✱ Develop screening and detection models.
- ✓ Expand Sexual Assault Examiner programmes to all communities.
- ✓ Develop and support the use of clinical tools.
- ✱ Ensure access to female examiners.
- ✱ Develop national protocols for forensic examinations, including how internal and external injuries should be documented and the difference in evidential requirements for stranger attacks and those perpetrated by known men.
- ✱ Develop national protocols for medical treatment, follow-up tests including assessment for pregnancy, testing for and treating STIs and where appropriate HIV.
- ✱ Develop models that include access to support, advocacy and counselling, which have a pro-active element.
- ✱ Ensure access to services and support for women in prison, women in the sex industry, refugees and asylum seekers.
- ✓ Protect confidentiality of medical records.
- ✓ Reduce or eliminate costs and reporting requirements in cases of sexual assault.
- ✓ Amend mandatory reporting requirements (where they exist) for adults to ensure that it increases safety and health, and does not deter reporting.
- ✓ Create funding mechanisms that improve the quality of care.
- ✓ Provide incentives for health providers to respond to violence against women.
- ✓ Prioritise integrated responses to sexual assault, domestic violence and stalking.

Whilst the extent to which it is possible to implement such measures will vary across resource rich and resource poor contexts, this distinction can lead to unwarranted assumptions. Some of the most innovative, well-staffed and well-resourced services are located in developing countries; whilst some extremely rich countries have done little to improve responses to rape and sexual assault for over a decade (Kelly and Regan, 2001). Two countries where a national model has been promoted – Canada and Malaysia - do not share the same level of national wealth and infrastructure, but what does connect them is an active and strategic women's movement, which played a part in ensuring that their governments made sexual/gender violence a priority, which in turn resulted in policy statements which required/expected hospitals to ensure access to a specified range of services.

One of the issues that is currently emerging from research is that forensic findings may have been overly valued, since, at least in Canada and the USA and with respect to adults, they appear to have minimal impact on the legal outcomes of cases. Furthermore, a number of forensic science tests have been criticised for lack of sensitivity and specificity (Ferris and Sandercock, 1998). These are major concerns because many victims submit to the indignities of the examination believing it will support their desire to seek justice (Feldberg, 1997). Despite this lack of influence on final outcomes, however, police, prosecutors and courts are likely to remain unsympathetic to complainants who refuse forensic examinations, both because they believe that the evidential findings are important, and refusal is read as a lack of cooperation at best, and a implicit sign that the accusation is false at worst. What is needed is more research on the role and impact of forensic evidence in the processing of rape complaints, especially comparing across both child and adult cases and investigative and adversarial legal systems. At the same time we should be encouraging forensic examiners and forensic scientists to

address the evidential differences between stranger and known male assailant cases. If they were to develop more accurate and sophisticated awareness and tools, these could challenge not only the continued belief, by many in the justice system and the general public, in 'real rape' but also the argument that rape cases are hard to prosecute because it is often 'just one person's word against another'.

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US Violence Against Women Office www.ojp.usdoj.gov/vawo

Sexual Assault Resource Service www.sane-sart.com

International Association of Forensic Nurses www.forensicnurse.org

Home Office Violence Against Women Programme
www.homeoffice.gov.uk/rds/violencewomen.html

Useful CD-ROM

Successfully Investigating Acquaintance Sexual Assault: A National Training Manual for Law Enforcement. Developed by the US National Center for Women and Policing.

Other RCNE reports available:

Rape: Still a Forgotten Issue. A Briefing paper for the Daphne Strengthening the Linkages Project, carried out by Prof. Liz Kelly and Linda Regan of the Child and Woman Abuse Studies Unit, London Metropolitan University.

Training Models and Accreditation Strategies – carried out by the RCNE and based on data from our European partners.

Best Practice Guidelines for NGOs supporting women who have experienced sexual violence – carried out by the RCNE and based on data from our European partners.

Country Reports from a number of members, namely: Czech Republic, Denmark, England and Wales, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Scotland, Sweden, Turkey.

Proceedings from the conference 'Sexual Violence: Issues and Responses across Europe, 3rd October 2003, Dublin, Ireland.

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