Overview and comparison of international models of service provision for victims of sexual assault

Final Report

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Executive summary

What the literature tells us about sexual assault services:

- Women who have experienced sexual assault have three main care needs: medical care; psychosocial care and assistance; and support from the criminal justice system.
- Evidence shows negative experiences are related to long waits for the forensic examination, and negative interactions with the examiner (e.g. disbelieving account of events).
- Responding to sexual assault requires addressing multiple dimensions of care in medical, psycho-social and legal sectors.
- How service providers respond to clients can have profound consequences for receiving appropriate care and later adjustment and recovery.
- Most of the literature focuses on understanding urban patterns of sexual assault and services.
- When designing models for intervention, 'one-size-fits-all' models are not recommended.

What the literature tells us about models of service provision:

Various models are used to meet forensic, medical, psychosocial and criminal justice needs in different countries and regions within countries. These include:

- **Co-ordinated services** that provide psychological, health, forensic and legal services in a single location.
- **Non co-ordinated services** whereby services are provided separately as part of mainstream provision.
- **Integrated services** whereby services for women who have been sexually assaulted are integrated within other relevant services (such as sexual health or violence against women)
- **Information and advice telephone helplines**
- **Support services provided by third sector organisations**

What the literature tells us about the effectiveness of models of provision:

There is evidence of two factors that reduced the risk of secondary victimisation of women by professionals when reporting sexual assault:

1. Having service providers in one location decreased the number of exposures to explaining the assault and accessing the range of services.

2. Training and specialisation in sexual assault contributed to questioning providers' beliefs and raising awareness of service users' emotional distress.

There is evidence that those seen by specialised sexual assault nurse examiners (SANE) receive more consistent and broad based medical care. Training and specialisation in sexual assault, either in the form of specialised service provision or by specialised professionals, will be more likely to offer thorough medical care.

Introducing a Forensic nurse examiner (FNE)/SANE programme in Scotland could be widely beneficial in addressing issues over the gender distribution of forensic examiners, as well as staffing shortages. Primary resistance appears to be around concerns of the validity of expert witness testimony in cases involving forensic nurse examiners. However, evidence from the USA where the tradition of forensic nurse examiners is much more established, suggests that this may not be an inherent issue with the model itself. Despite multiple legal challenges, no case involving an FNE/SANE has been successfully overturned due to FNE/SANE testimony.

This review did not find evidence on whether sexual assault services delivered in services which also cover a range of other forms of violence against women and children are more or less effective than those services that only specialise on sexual assault.

There are few evaluations conducted specifically on sexual assault interventions in Europe. However, evidence and studies from elsewhere suggest that service provision must recognise the full range of needs that women who have been sexually assaulted experience. This means that services need to be evaluated for effectiveness on multiple domains in order to ascertain their effectiveness.

What the literature tells us about "best practice".

Evidence shows a number of features of good practice that policy makers and service providers should build in to service design and provision to improve the effectiveness and accessibility of services. These include:

- Providing comprehensive care and support for the medical, psycho-social and legal needs of service users

- Providing co-ordinated, specialised services in sexual assault

- Providing staff training on technical aspects of service provision and crisis intervention
- Encouraging staff specialization in sexual assault
- Ensuring sexual assault is not missed by integrated services
- Providing services without time limits, i.e. independently of when the assault occurred, and accessible 7 days a week and 24 hours a day
- Reducing variability in service quality and accessibility
- Providing language support
- Providing childcare and other social services (e.g. shelter, refuge)
- Providing self-referral pathways to access services
- Providing information on the intended course of action and obtaining service user's consent
- Ensuring that services are, and are perceived to be, independent and confidential.

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Preface

This paper seeks to provide insight into the current "best practice" in service delivery and an overview of the service provision models utilised internationally. The focus was on services that provide a forensic medical examination as part of their service delivery. The diversity of the services included, reflects the complex nature of sexual assault and the need for services to be able to respond adequately. The best practice indicators covered in this paper are extensive but are not necessarily exhaustive. Stakeholders are encouraged to take these features of good practice into consideration when establishing and improving support services and developing programs for victims of sexual assault.

The literature is split on the preferred terminology when discussing sexual assault service users, the most commonly used terms are either 'victim/s' or 'survivor/s'; with nursing/medical sources opting to use the term 'client' instead. As such, this paper will use the terms interchangeably to match its respective source material.

Methodology

The literature review included peer reviewed articles in academic and scientific journals as well as grey literature. Grey literature was defined as:

- Reports published by international agencies including the UN and the European Commission;
- Reports and strategies issued by national and regional government agencies;
- Reports issued by NGOs.

The focus of the paper was on women aged over 16. This was due to the focus on women's services within the literature as well as the gender disparity in reported cases of sexual assault. Although most of the features of best practice could be beneficially adopted for services aimed at men, their needs and circumstance are often different; therefore their services will need to be tailored differently as well.

In this report, 'sexual assault' will be used to refer to all types of sexual violence. In addition, the focus was around services that employ a medical evidentiary examination as part of service delivery (even if this does not require reporting to the police) for victims rather than perpetrators of sexual assault.

Quality of the evidence

Different types of documents provide evidence of varying quality. While peer reviewed articles in academic journals have findings based on robust methodologies and verifiable data, grey literature is often less verifiable and more descriptive. This means information and data taken from different types of literature are not directly comparable and, therefore, cannot be reliably aggregated.

In addition there is also a lack of systematic evaluation of sexual assault services internationally. Given the lack of systematic evaluation and the disparity in the types of evidence available, it is not possible to develop a methodologically sound hierarchy or framework which directly compares the effectiveness of different intervention and service models. As such, grey literature formed much of the foundation of this review. In general the grey literature has been used for descriptive purposes, to help identify and explain how sexual assault is dealt with in different countries.

Furthermore, due to the lack of systematic evaluations, the time frame referenced in this report is relatively expansive (2003-2018). This was done in order to incorporate any seminal pieces of work found. However a consequence of such an approach is that information about specific programmes may currently be outdated. Therefore caution is advised when referencing specific findings or figures.

Common methodological issues found in the literature:

- Countries have different legislative definitions of sexual assault and this has an impact on levels of reporting.

- Countries do not use the same standard definitions and methodologies in estimating prevalence of sexual assault. Prevalence levels are sometimes based on self-reporting in population-based surveys whereas other times they are based on official crime statistics. This makes it problematic to compare countries or aggregate figures.

- All methodologies are likely to underestimate the real number of cases, as many assaults are unreported and some forms of sexual violence may be not be perceived by victims or perpetrators as an offence. Population-based surveys are recommended as better estimate predictors.

- There are no commonly agreed indicators for measuring the effectiveness and accessibility of sexual assault services.

- Sexual assault requires a multi-sectoral response to medical, psychological and legal needs, which complicates measuring the effectiveness of services.

Steps to improve data collection/evaluation of services in the future

- Systematic evaluation of services for women who have been sexually assaulted is necessary to improve the effectiveness of services.

- Two types of indicators have been suggested as reliable measures of service effectiveness: those that measure the wellbeing and health outcomes of the service user; and those that measure services such as user satisfaction.

- More evaluations should be conducted in lower resource settings to test the effectiveness of interventions and also identify new evidence in these contexts.

1. Chapter 1

1.1 Role of the forensic examiner and forensic examination

When a person reports an instance of sexual assault either to the police or through self-referral, they will be often be asked to undertake a medical evidentiary examination as part of the legal process of evidence collection, as well as an attempt at frontline medical intervention. A medical evidentiary examination is a process enacted by a health professional that attempts to meet the dual aims of; attending to the needs of the victim, as well as the needs of the legal system. The process is also known as a medico-legal examination, or a sexual assault forensic examination[1]. An examination typically includes: medical evaluation and crisis intervention; forensic evidence collection; evaluation of emotional needs; and referral for follow-up care[1]. Should legal proceedings progress to a court hearing, the forensic examiner may be called upon to provide expert opinion or provide a statement in regards to the evidence recorded, or the demeanour of the complainant during the examination [1].

Some research has suggested that forensic evidence gathered in this process, increases the likelihood of legal action against perpetrators[4,] with one US study finding that having a forensic examination doubled the likelihood of a prosecution (Lindsay 1998,cited in [4]). However other research has found that only documented severe injury appears to predict a conviction[4]. Beyond the potential benefit to the legal system, forensic examinations in cases of rape and sexual assault have also been correlated with greater access to health and support services, which in turn is correlated with improved outcomes. Over half of those who report the assault accessed medical treatment, compared to under a fifth of those who chose not to report (Rennison, 2002; Resnick et al, 2000, cited in [4]). These results demonstrate the potential benefit that the reporting and examination process has in fulfilling the dual role of the forensic examination, as both a frontline medical intervention/evaluation, and as an evidence gathering process.

On the other hand, the dual role held by the forensic examiner and the forensic evidence gathering process as a whole, is not without its tensions. Indeed, one of the key potential pitfalls in the process is the misalignment of expectations between those accessing the service and those administering it. Both patient and physician need to have a clear understanding of the role in which the forensic examiner is undertaking the examination, and the key differences this may have with the usual doctor/patient dynamic. Leane et al, (2001, cited in [5]) found that the attitude and approach of the individual examiner has a significant influence on the victim's experience of the examination. This research also indicated that professionals can be influenced by assumptions and myths about rape/sexual assault victims, which can in turn result in professional practice that negatively impacts victims' credibility and their needs being met. These factors can subsequently contribute to compromised testimony when appearing as a professional witness should the case go to trial[5].

Therefore, for both the complainant and the criminal justice system, it is imperative that access to, and practice within, sexual assault services combines availability, sensitivity, awareness and professional standards[4]. Medical examiners need to be aware of the meaning of both rape and forensic examinations for victims/survivors, and ensure they mitigate the effect of any pre-held conceptions/assumptions. They also need to be aware of the legal context in which they are gathering evidence and the skills, experience, and technical resources needed to adapt the process to the specifics of each case.[4]

2. Chapter 2

2.1 International models of service delivery

Internationally there is significant variability in service features and provision, determined by each individual country and protocol. Collecting forensic evidence is most typically done in a police station special facility or in emergency hospital departments. However, genitourinary medicine clinics or other local health or community service are also used based on circumstances[2]. The examinations are frequently performed by forensic doctors, but can also be performed by physicians on call, gynaecologists or sexual assault nurse examiners (SANE). A common protocol across countries is to use a 'rape kit' which provides instructions and equipment to collect forensic evidence[2], though these 'kits' are not necessarily standardised across locations within a country/region.

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. Therefore, the responses that service users encounter depend not only on which country they live in, but also *where* they live within the country[4]. Typically, variability in service delivery corresponds to an urban/rural divide, however as in the case of the United States, differences in state legislation can also have significant effects on service provision[1].

2.2 General features of models of provision

The EU funded project 'Comparing Sexual Assault Interventions Across Europe' (COSAI) published its final report in 2013. The project was a 5 year investigation, with the aim "*to improve the effectiveness, appropriateness and humanity of sexual assault services by reviewing current practice and taking on board user attitudes to interventions following sexual assault, and therefore decrease the social, mental and health harm caused to the victims of sexual assault*"[2]. The COSAI project found that across EU countries there are a range of models for delivering services. These include:

- **Co-ordinated services**: Co-ordinated services, which are also sometimes referred to as 'dedicated' or 'specialist' services, bring together police, prosecutors, doctors, nurses, social workers, and rape victim advocates to provide psychological, health and forensic services in a single location, usually a centre in a hospital setting. Typically a person can access these services by

presenting to the police or a health care provider or by self-referral. An important feature is that the examination for medical and forensic purposes is done as a single examination; all services are accessed in a single location and a multidisciplinary team works together to meet the victim's needs. Out of the 34 countries looked at by the COSAI project mapping, 14 countries (41%) had centres offering coordinated and specialist services for sexual assault victims. However, in some of these countries the services did not cover every region.[2]

- **Non-coordinated services:** Services are provided separately and in different locations as part of mainstream service provision. Services that women who have been sexually assaulted can use include: emergency departments in hospitals, sexual health clinics, forensic medical services, counselling and psychiatric services, the police, and the courts. Medical and forensic examinations are done separately and the degree of liaison between service providers is usually minimal. Out of the 34 countries looked at by the COSAI project mapping, 16 countries (47%) provided services in this way[2].

- **Integrated services:** Services for women who have been sexually assaulted are integrated within other services for women. While coordinated models have aspects of integration in that they provide multidisciplinary services, they are dedicated to the needs of women who have experienced sexual violence. Integrated service models on the other hand also cover a range of other forms of violence against women and children e.g. domestic abuse. Out of the 34 countries looked at by the COSAI project mapping, two countries (6%) provided services in this way [2].

- **Information and advice telephone helplines:** Services that offer women a range of support including: advice on how to access services, legal information, and psychological support. They are anonymous. Some are exclusively aimed at women who have experienced sexual assault and others are aimed at women experiencing any type of violence. Some are provided by government agencies and some are provided by NGOs and funded through government, charitable and/or private funding. Such services were identified in 12 countries (36%) as part of the COSAI project's mapping. [2]

- **Support services provided by Non-Governmental (NGOs):** In addition to the services described above, most of the 34 countries included in the mapping had NGOs that provide support to women who have experienced sexual assault. These NGOs include those that focus on sexual assault specifically and those that focus on broader forms of violence and discrimination. They often concentrate on providing advice and counselling for women. Many are also engaged in advocating for improved services and awareness. In some instances, these NGOs have close links with coordinated services and there are pathways or referral between them [2].

- **Prevention programmes**: Prevention programmes aim to reduce the incidence of sexual assault. Between 61% and 75% of respondents to a survey covering 22 European countries said prevention programmes such as school-based programmes to prevent violence in dating relationships, changing cultural norms to gender inequality, changing cultural norms that support intimate partner

violence and changing cultural norms that support sexual violence were in place in their country[2].

2.3 Specific examples of models of service provision

2.3.1 Trained doctors in a co-ordinated scheme

This is 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 general forensic examiners, who therefore have limited specialised knowledge with respect to sexual assault. Recruits tend to be male, however a number of countries have developed schemes that enable them to recruit more women, and there have been moves to increase specialisation in examining adults and children in sexual offence cases[4.]

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 coordination and integration across the agencies involved; poor links with follow up services; and absence of integrated crisis intervention and advocacy services[4].

2.3.2 Sexual Assault Centres (SACs)

SACs(also referred to as Sexual Assault Referral Centres (SART) have been one response to criticisms of existing service provision by women's groups and survivors, as well as recognition of the gaps in service delivery by agencies such as the police. Criticisms of previous service provision included; a lack of choice in the gender of the forensic examiner, inadequate forensic facilities, as well as large delays between admission to a service and the arrangement/administration of a forensic examination. SACs aim to provide a high standard of comprehensive care to anyone who has experienced recent sexual assault, and overcome the historic criticisms listed above.

There are a number of models of Sexual Assault Centres, however they all share the same tenants of multidisciplinary co-ordination. Many countries have hospital based provision, whilst others, provide a standalone community based option. Some, have extensive networks, for example Canada; whereas others such as Germany, Switzerland and England/Wales have a smaller number of centres - often in major cities or locations. Uneven service provision across regions was a consistent pattern observed across countries.

SACs tend to be limited to recent sexual assaults, i.e. those that have taken place within the last two weeks, and are available to women, men and children[4]. 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, at least one of which is equipped for forensic examinations[4]. Privacy and confidentiality are key principles in service delivery.

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. The storage of samples allows for the decision about reporting to be taken at a later date.

Regional variation

In North America there is often a strong victim advocacy programme which may be based in the prosecutor's office, or even rape crisis centres, and the advocates are expected to link in at the earliest point, i.e. when someone first attends a SAC. A number of SACs, especially in Canada, have integrated pro-active follow up within the first week of attendance[4].

In England and Wales, Independent Sexual Violence Advisers (ISVAs) are expected to work with victims to support them and enable access to the services they need. They provide impartial advice to the victim on all options open to them throughout and beyond the criminal justice process, such as accessing a SAC, reporting to the police, seeking support from specialist sexual violence organisations and other services, such as housing or benefits (HM Government 2011b, cited in [2]).

The Australian model (termed Sexual Assault Services, SAS) emphasises longer-term continuity of care and advocacy, rather than crisis intervention and forensic examination[4]. 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. 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, nor do they have to function within the bureaucratic rules of a large government institution. They have much in common with well-funded rape crisis centres, undertaking longer term support of adult survivors of child sexual abuse than would be found in other SACs. 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[4, 5] .This approach was commented on as providing a greater degree of privacy to users of the service; however delays and lack of choice in the gender of the examiner were noted as frequent issues[4].

SACs in Scotland

Although SACs are widely regarded as an improvement in service provision over previous models that employed a standalone examination suite. There are aspects that need to be considered before the commissioning of such a service to meet local need. The evidence for the overall cost effectiveness of SACs compared to alternate models in the literature was limited. This scarcity of analysis was most likely attributable to the difficulty of comparing individual SAC services with alternative models. This difficulty would be due to the variance in services provided, resource allocation, local context, differences in overall aims of the individual model (e.g. a

more health or justice focus), as well as a lack of evaluative information. As such arguments for the establishment of SACs have traditionally been made on the grounds of improvement in service delivery and increases in "procedural justice", rather than cost effectiveness of service delivery[12]. Indeed Lovett et al (2004, pg. 75) argue that "*Assessments of the worth and relevance of SARCs in any locality has to be taken using criteria other than cost effectiveness alone*", as inevitably SACs are more expensive to run than the basic rape examination suites that preceded them [11, 12]. This increased cost is a natural consequence of the increased number of services provided by SACs as well as the multiagency approach necessary in order for SACs to be optimally utilised. In addition, the requirement for SACs to be staffed and available 24 hours a day, translates to a process that is resource intensive, both in staffing recruitment and upkeep, and overall funding demand. Indeed, even Archway in Glasgow, Scotland's only SAC facilitate, has had issues with maintaining continuous 24 hour availability to potential clients, despite being situated within one of Scotland's main urban centres[6]. Nevertheless, the argument has been made that the services provided by SACs provide a potential long term saving, as the improvement in service delivery and outcomes, potentially leads to a reduction in the need for access to additional/follow up services over time[12,13].

In addition, beyond general budgetary concerns, it is necessary to ensure that the location itself allows staff to be adequately trained and updated on relevant skills and competencies[11]. This interaction between budgetary allowance and density of need is most often an issue in rural and/or remote areas, and is cited as one of the most limiting factors to the sustainability of sexual assault services[11]. In such situations, alternative models could be deployed at a local level that still meet the clients' needs for comprehensive support and care, whilst still ensuring the validity of the medico-legal evidence gathering process. The appropriateness of a nationwide SAC model was addressed by the UK government in their response to the Stern report, and acknowledged that a "one size fits all" model of service provision was not necessarily appropriate in all locals[11].

Given the make-up and typography of Scotland, consideration of such alternative local models outside of the large urban centres appears prudent. Specific suggestions were provided in the literature that could meet the services aims whilst being sensitive to local conditions. The majority of the suggestions provided fall under the idea of a "hub and spoke" model in which larger regional "hubs" provided support to smaller local "spokes" that in turn provided varying degrees of service provision. Some envisioned the spokes as being comprised of local health services[3], others suggested that the spokes would act as avenues for follow up care[11], whilst some envisioned a larger role for the spokes acting as smaller satellite centres or dispersed networks of remote practitioners which may be 'attached' to other appropriate mainstream services or operate during out of hours periods on an 'as needed' basis[6]. The latter approach is similar to how rural/remote service provision operates in the USA and Australia through the use of Forensic Nurse Examiners (FNEs).

2.3.3 Centre of excellence

In Nordic countries (namely Norway, Iceland, Sweden and Denmark) the model is referred to as a centre of excellence. These multidisciplinary and victim-focussed centres started as early as 1986, they are always hospital-based and often developed through the vision and leadership of a single doctor. The centres often receive government endorsement and funding (Kelly & Regan 2003; Bramsen et al. 2009)[2].

The centres operate under well-developed standards and specialise in the emergency response to recent rape and sexual assault through the provision of core services for emergency medical treatment and care. The centres also deliver forensic examination and crisis counselling through referral to a psychologist, who is available immediately after the assault and in the follow-up. The centres can also provide treatment for people around the victim, who are emotionally affected or secondarily traumatised by the assault. In addition, they are required to provide options for the victim to spend the night in a safe environment[2]. Victim outcome assessments are ensured through a follow-up questionnaire six months after the assault, which may also involve a phone call if the person does not respond to the survey.

These centres have highly skilled and trained staff on dealing with sexual assault, including the availability of trained nurses, similar to the Sexual Assault Nurse Examiner model (which will be discussed in chapter 3), to accompany the victim through the entire process, including questioning by police and ensuring medical, psychological and legal procedures in the aftermath and follow-up of the assault [2]. A key distinguishing feature of the centres is their focus on research and evaluation, which includes service satisfaction surveys with victims; treatment assessment outcomes in terms of PTSD symptoms; psychological and relational readjustment; and family coping[2].

The centres represent a national resource, usually based 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. Such services specialise in the emergency response to recent rape/sexual assault and therefore encompass forensic medical examinations and treatment informed by research and crisis counselling. There tends to be very strong links with other agencies, especially the police and prosecutors. Their role is to be an example of best practice within the country, continually updating knowledge and skills of those within the system, in accordance with their own and the international knowledge base. While those who attend such centres will be seen by skilled and experienced staff. There are however, a number of disadvantages for those outside of the catchment area who cannot access the services. Resources tend to be drawn to the centre, with limited development and provision provided elsewhere (Kelly and Regan, 2003a)[5]. Although for countries with relatively small populations and landmass, these limitations are likely to be less pronounced[4].

2.3.4 Integrated models

Another model of service provision described in the literature is where sexual assault services are integrated within other services for women. While co-ordinated models have aspects of integration in that they provide multidisciplinary services, they are dedicated to the needs of women who have experienced sexual violence. Integrated service models on the other hand, also cover a range of other forms of violence against women and children. The services offered include health, legal, welfare and counselling services in one location and they are often located in the accident and emergency department of urban hospitals (Colombini et al. 2008, cited in [2]). These models are found most commonly in developing countries, especially Asia, but also the US and Canada. Kelly & Regan (2003) explain this prevalence with a need to maximise scarce resources. This review did not find evidence on whether integrated services are more or less effective than those services that only specialise on sexual assault.

3. Chapter 3

3.1 Forensic nursing

Although systematic evaluations of service delivery were sporadic in the literature, there was a substantial amount of work investigating the efficacy of using forensic nurses as primary and secondary administrators of forensic examinations in cases of sexual assault. Forensic nursing is the application of nursing science to public and legal proceedings. A forensic nurse is expected to provide direct services to patients/service users, as well as provide professional consultation and services for police and the legal system. A range of specialisations have developed within forensic nursing, one of which is termed the Sexual Assault Nurse Examiner (SANE). The basic SANE program is available to trained registered nurses, and offers certification as a nurse examiner on completion of classroom and clinical training. Typically, programmes require 40 or more hours of classroom instruction, along with clinical training and subsequent continuing education. SANE programmes are often integrated into a Sexual Assault Response Team (SART) model for the delivery of emergency medical care to survivors of sexual assault.[1].

Whilst their area of expertise began in adult rape and sexual assault, forensic nursing has expanded to encompass child sexual abuse, as well as domestic violence. Various models of service provision exist, currently most provide an integrated forensic service, and many are part of multi-disciplinary SARTs. Many schemes have direct partnerships with victim advocacy programmes (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.

Forensic nurse examiners now conduct the majority of sexual assault forensic examinations in the USA, and are also strongly established in Canada. In North America most forensic nurse models are hospital based. The model is most often employed in urban centres; however there have been important developments in adapting models to rural and remote regions. The literature suggests that in the USA, SANEs often have a longer and more in depth training than most forensic doctors in sexual assault cases, with guidelines recommending that a minimum of ten examinations per year be undertaken to maintain expertise[4] (though some of the

evaluative work referenced suggests this is may be more aspirational than standard in some hospital settings)[1].

Some of the advantages of forensic nursing highlighted in the literature are:

- Increased likelihood of being able to provide a female examiner due to the typical gender ratio of nursing;
- 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';
- Provision can be less expensive than that involving doctors; and
- Organised forensic nurses have become strong advocates for ensuring minimum standards development and implementation[4].

3.1.1 Forensic nursing in the UK

Forensic Nurse Examiners (FNEs) have been independently conducting forensic examinations on the survivors of rape and sexual assault in the UK since 2001. Introduced in order to cover the rota during the day (a time that is traditionally difficult for doctors given their various other roles), the introduction of nurses was an attempt to reduce the length of time that survivors had to wait to be seen by a forensic medical practitioner. The waiting time and the gender of the forensic practitioner were two longstanding criticisms levelled at forensic medicine, and the introduction of nurses was a means of addressing both issues.

However following their initial introduction, the uptake of FNEs has been limited[7]. Although a full evaluation of this lukewarm uptake is outwith the scope of the review, issues appear to stem from tensions over jurisdiction between Doctors and forensic nurses, ambiguity over the perceived role of FNEs in a multidisciplinary team, as well as general service implementation issues. Nevertheless, evidence from pilot work conducted in England and Wales, as well as the longer tradition of FNEs in North America, suggest that these are most likely issues of implementation and changes to cultural norms, rather than inherent issues with the FNE model in sexual assault service provision.

The role of forensic nurses in the criminal justice system was not specifically investigated, as it was outwith the specific focus of the brief comparative review.

3.1.2 Best practice in Forensic nursing: case study from Ontario, Canada

The Network of Sexual Assault and Domestic Violence Treatment Centres (hereafter referred to as "Network") in Canada is often exemplified as a model of best practice in the use of forensic nurse examiners[7]. The selection process is noted for its rigour,

with some centres having a year-long recruitment process. This recruitment process involves multiple meetings with the applicant and the shadowing of more experienced nurses in order to ensure that the new recruit has the appropriate temperament and attitude for the role[7] During shadowing of more experienced staff, the nurse is expected to observe the detail of the examination itself, as well as the manner in which the forensic practitioner interacts with the client. In some centres, role-play exercises are used to assess whether a nurse has been able to adopt a non-judgmental attitude. Displaying this disposition is necessary before the nurses are allowed to practice independently. These role play exercises typically involve a member of a victims' advocacy service playing the role of the client. While the nurse must perform the examination itself competently, it is actually the way that they interact with the client that is the primary criteria of interest[7].

In Ontario, if the centre co-ordinators agree that the trainee nurse displays the appropriate attitude then they are free to perform independently, and after a year are invited to attend SANE training. In the last 10 years, SANE training has started to focus on the legal requirements of the SANE role as well as the medical nature of the role. In the past, nurses were also trained to perform gynaecological examinations; however, given that nurses normally have a year's experience by the time they attend SANE training, this is no longer considered necessary. The focus is now predominately on the relationship between the nurse and other members of the criminal justice system, providing nurses with experience of the courtroom as well as allowing them to make contact with other legal staff[7].

The Network places considerable emphasis upon client empowerment, and it is the SANE's role to uncover and provide the medical and legal options that are available to the client (collection of trace material, contraception, prophylactic medications, etc.) In order to avoid undue pressure on the client to undergo an examination, SANEs ensure that clients are taken into the examination suite (a room the police are prohibited from entering) very soon after their initial arrival. During this period the nurse will attempt to ascertain if the client does wish to be there and provides all the options as to the ways in which the examination will proceed[7].

SANEs ensure that the "chain of custody" is preserved, an element crucial for both the validity of the forensic evidence gathering process, and to ensure that they can claim (if they are required to go to court) that the evidence could not have been tampered with. The Network's centres are based within hospitals, enabling quick turnarounds on any necessary tests. If the kit has been opened, the nurse is required to carry it with her at all times. Leaving the kit could break the chain of custody; therefore once the kit is open, the space is as evidential as it is therapeutic.[7]

UK SACs are located in purpose-built buildings on hospital property and so FNEs do not have the same concerns about moving clients through the hospital that some SANE's in Canada expressed[7]. The potential for contamination of evidence is a chief reason for placing SACs in separate buildings; that way, they can have specialist cleaning protocols independent to the rest of the hospital. This is one of the advantages that SACs in the UK have over services that are integrated into local hospital settings.

3.1.3 Differences between the role of FNEs in Canada and the UK

Although this review did not specifically aim to examine the role of FNEs in the criminal justice system of the individual countries examined, Rees (2011) noted a few substantial differences between the practice of the Canadian and English nurses in their study. Much of this difference revolved around the way the various actors within the system interacted with each other, which was in turn substantially influenced by how their role interacted with the criminal justice system.

In Ontario, doctors do not wish to perform forensic medical examinations or provide evidence in court, and are happy for SANEs to fulfil that function. However, SANEs are not actually considered experts in the Ontario context unless they prove themselves to be so during the court case (for example drawing upon the number of cases they have examined). Very few SANEs wish to claim this expertise, and instead rely upon their documentation "*to keep [them] out of court*"[7]. To this end, nurses perform the examination, including completion of documentation, and it is these forms that constitute the forensic medical evidence in the courtroom, with nurses very rarely having to provide testimony. If the prosecution do require expert reports, the centre co-ordinator (generally a SANE who works full-time) fills that role. However, they do not provide evidence about the specifics of the case, but rather generalities, for instance the finding that injuries are frequently not present on survivors' bodies[7]. This division of labour is yet to happen in the United Kingdom.

SANEs generally provide two types of nursing documents: standardised protocol documents with tick-boxes, or open-ended documents in which they record the client's answers to highly specific closed questions which the nurse has been trained to ask (number of assailants, use of a condom, etc.). To this end, the nurse only records information either expressly requested upon the form or of the type that they have been trained to generate; the benefit of such an approach is that if the client does mention other information that is not requested on the forms (previous terminations of pregnancy for instance), the nurse does not have to record it.[7] In contrast FNEs in England were found to record additional information that was not specifically requested on their standardised protocol documents. When questioned on this, nurses in England agreed that the information (e.g. termination of unwanted pregnancy) was irrelevant to the case and was not asked for on the form, however they commented that they would still add it to their documentation, arguing that it may become relevant to the doctor's expert testimony, and stated that they had a concern that if they did not record such information they could be accused of conducting an incomplete examination[7]. Moreover, in an effort to prove that they have performed the examination thoroughly, they consider it best practice to record all physical phenomena, including tattoos and piercings, as by doing so the nurse can show the court that she has examined the client from "top-to-toe". [7] Both of these practices are problematic in an adversarial legal system, as the nurses' reporting documents are disclosed to both the prosecution and defence, and the use of sexual history and bad character evidence in sexual offence cases have previously been used by in order to discredit the complainant during cross-examination[7].

3.1.4 Forensic nurse examiners in Scotland

Some health service providers across the UK have suggested that the labour market in rural/remote areas makes it easier to recruit and retain high calibre nurses than high calibre doctors, and that sexual health nurses with appropriate additional training in forensic practice can enable a high quality, integrated and victim centred service in responding to cases of sexual assault[6]. Such an approach underpins the way SANE networks operate in rural areas in the USA and the nurse led first contact approach in Australia. This approach requires staff to be well-integrated into a wider established system of support (with an emphasis on training and continual professional development); referral; and general partnership working. Partnership with other agencies is essential as the nurses' professional expertise needs to be recognised and accepted as a key part of the overall system[6]. The "hub and spoke" model employed in England and Denmark may provide an efficient way of approaching such a service, with SACs in urban areas providing support to SANE networks in more rural and remote areas e.g. clinical guidance from doctors, wider support and training networks etc.

Qualitative research conducted found that the most commonly cited resistance to the increased use of FNEs in Scotland was the reaction of the Crown Office and Prosecutor Fiscal's Office (COPFS). There was a strong perception that COPFS do not believe that nurses could offer credible evidence in court and fear that as a result defence lawyers will engage in aggressive cross examination or bring in competing 'expert' opinion to undermine a nurse's professional evidence[6].

The COPFS' submitted response to this report in regards to the implementation of nurse examiners is Scotland is provided below:

"*The effective provision of forensic medical services is of the utmost importance to the investigation and prosecution of crime in Scotland. In relation to this, it is critical that forensic medical services are sufficient to satisfy the specific requirements of the Scottish legal system in terms of the adequacy, admissibility and reliability of the factual and expert opinion evidence which would be required to be led in court in relation to a criminal prosecution. In order to consider a wider use of FNEs in Scotland, concrete proposals to meet these requirements, including in relation to appropriate training and qualifications, would be required*."

In the USA where SANEs have a longer tradition, there have been multiple challenges to SANE credentials as expert witnesses. These appellate reviews include evaluating the qualifications of SANEs as an expert witness and analysing the nature and scope of SANE forensic testimony (both fact and expert testimony). To date, these courts have rejected all defence challenges to convictions based on SANE testimony[6]. HMICS also found no examples of criminal cases being compromised due to the medical evidence being provided by a nurse as opposed to a doctor[3]. In addition, possible suggestions on how to meet the requirements of the Scottish legal system highlighted by COPFS were provided by Jarvis (2014). These included:

- Clear qualifications and training/development pathways for FNEs to ensure their professional status and expertise is unquestionable.

- Advanced training on court witness roles as per the PgC/PgD/MSc in advanced forensic practice.

- Improved and consistent documentation to ensure professional forensic evidence is presented in a way that leaves less room for error, omission or misinterpretation.

- Clearer guidelines on the meaning of 'neutral evidence' and absence of injury with consideration given to judges referring 'neutral' evidence to be agreed between defence and prosecution in advance.

- A potentially increased and proactive role for judges in explaining to juries issues such as the relationship between forensic evidence and consent.

- Alternative use of supervisory medical directors to give evidence in court (as per the way SPA senior staff currently provide professional evidence on the basis of the work of forensic examiners or the way in which currently one FME might give evidence on the basis of another FME's examination)

Furthermore, alternative quality control mechanisms in relation to courts evidence were also suggested, such as in Norway, where a panel of experts consistently assesses all examinations and documentation at a national level before proceeding to court, and provide expert overview that the chair or a representative of that panel can then speak to if required[6]. Alternatively, the approach highlighted above in Ontario could provide a way of mitigating individual concerns, by having senior SANEs providing general testimony on a case, and the individual documentation providing in-depth details and results. It is recommended that the potential adoption of these options should receive further consideration in regards to the prospective benefit it may provide to the current system, as well as the feasibility of the implementation of such suggestions within Scotland.

4. Chapter 4

4.1 Improving services/best practice

Throughout the literature review, a number of features were highlighted as evidence of good or "best" practice. Generally, the literature advocates for a collaborative approach to service delivery where there is consistency and support at all levels for victims of sexual assault. This collaboration and sharing of knowledge is also a common themes throughout the literature when commenting on where sexual assault services can be lacking.

Not surprisingly there was also significant overlap in the nature of the comments on what constituted good practice in ensuring this joint up, collaborative approach. Although there may have been slight variation or emphasis in specific suggestions, these were the common features highlighted within the literature, split into broad categories:

4.1.1 Logistical elements:

- Recognize essential elements of initial response.
- Identify key responders and their roles.
- Develop quality assurance measures to ensure effective response during the exam process.
- Build consensus amongst involved agencies regarding procedures for a coordinated initial response when a recent sexual assault is disclosed or reported. Educate responders to follow these procedures.
- Develop and ingrain philosophical principles underpinning practice that emphasise respect, dignity, rights and choice.
- Enhance forensic practice through capacity building – both the number of trained examiners (often through involving nurses) and their skills base.
- Ensure access to female examiners (though much of the literature suggests female examiners as the default choice).
- Link provision of immediate medical care, forensic examinations, crisis and short term counselling, follow up medical care and advocacy.
- Combine service provision with training, awareness raising, and system advocacy.
- Integrate support and advocacy services into service provision. [9]
- Increase networking between specialist Non-Government Organisations.[9]
- Ensure access is as wide as possible, and that outreach efforts are targeted at under-served populations. [4]

4.1.2 Victim-centered care:

- Ensure a speedy response in service delivery from a service user's initial contact with an agency.
- Avoid the triage system in hospital A&E departments.
- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.

- Develop culturally responsive care and awareness of issues commonly faced by victims from specific populations.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Any additional needs (such as interpreting or communication) are addressed;
- Ensure the process is understood as a fluid and interactive one.
- Informed consent is sought at the outset, and for each procedure[7].
- Offer as much control to the victim throughout as is possible.
- Integration, as far as possible, of medical and forensic procedures.
- Discussion of safety planning before discharge.
- Routine mechanisms for follow up and advocacy.
- Time to move at the speed the victim is comfortable with.
- Recognize the importance of victim services within the exam process. [8]
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counsellor/advisor/healer) present during the exam, unless considered harmful by responders. [8]
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible. [8]
- Assess and respect patients' priorities. [8]
- Address physical comfort needs of patients prior to discharge. [8]
- Ensure 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.[4]

4.1.3 Training/education

- Encourage the development of specific knowledge, skills, and victim-centred approaches in examiners.
- Encourage advanced education and supervised clinical practice of examiners, as well as certification for all examiners.

- Provide access to experts on anti-sexual assault initiatives who can participate in sexual assault examiner training, mentoring, proctoring, case review, photograph review, and quality assurance.

- More emphasis is needed on professional training, competence, CPD and regular practice/support of those involved in forensic medical examinations.[6]

- Ensure 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.

4.1.4 Facilities

- The examination should be 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.[4]

- Protocols and evidence kits need to have the capacity to be applied flexibly, according to the facts of the case.[4]

- The facility needs to have a space to discuss the process, debrief and undertake crisis intervention.[4]

- The facility needs to have the necessary resources to meet the basic comforts a victim would need both pre and post examination e.g. change of clothes, shower facilities, access to a telephone etc.

- Ensure that exams are conducted at sites served by examiners with advanced education and clinical experience, if possible.

- Explore possibilities for optimal site locations. Certain guidelines specifically recommend hospitals as the prime local, however the evidence for this was often lacking.

- Communities may wish to consider developing basic requirements for designated exam sites.

- If a transfer from one health care facility to a designated exam site is necessary, use a protocol that minimizes time delays and loss of evidence and addresses patients' needs.[8]

- If facilities are using offsite consultation with medical experts, they should be careful to protect patient confidentiality, especially in cases involving the retention and transfer of photographic images.

- Use kits that meet or exceed minimum guidelines for contents.

- Work to standardize sexual assault evidence collection kits across geographical locations.

- Ensure facilities have a private, dedicated space for the examination [4]

- The examination room needs to be well equipped and meet the necessary forensic standards in terms of cleanliness/sterilisation.

- If the facilities are based in a location with multiple patient types, victims should be accorded priority.[4]

- Injuries should be assessed immediately, and where necessary treated[4].

4.2 Specific suggestions

- Develop a clear professional pathway and consistent training approach for a new cohort of specialist forensic nurse examiners in Scotland. This will help address issues around staffing and choice of gender in examiners, as well as provide rural and remote areas with a wider pool of potential examiners to draw upon.

- Take advantage of advancements in technology to establish collaborative training and support between more established urban centres and more remote and rural areas. This will help provide areas with much needed expertise, as well as take advantage of the greater resource concentration in urban areas. In addition this could act as an avenue for skill maintenance for those directly involved, and the encouragement of collaborative processes between services.

- Ascertain the appeal of a 'hub and spoke model' to employ in areas that may not be appropriate for the establishment of a SARC. England and Denmark are currently utilising such a model with the aim of reducing costs, whilst maintaining consistency of service. The effectiveness of this system could not be verified due to the lack of evidentiary information. However the idea has received hypothetical support from stakeholder as a suitable model to be employed outside of Scotland's urban centres.

- Limit documentation to the information specifically requested upon the forms (unless they have been told by another authority that something else is relevant). The standardised forms should be evaluated by those with legal expertise to ensure they meet the necessary requirements of evidence collection necessary should a case go to trial.

- Closer collaboration between doctors and nurses is vital in the United Kingdom in order to improve the confidence of FNEs. Doctors and nurses should have a clear understanding as to the information that should be recorded for the examination itself, and for any subsequent court appearance as an expert witness. Familiarity with the role of the expert witness in sexual

assault cases, will reduce the quantity of irrelevant and problematic information being recorded on disclosable documents.

- Develop a national protocol and shared approach to deliver a locally appropriate service that ensures consistent national standards of forensic examination and care and positive impact on all three stages of the presentation and progression pathway. [6] This approach would move away from the idea of individual centres of good practice, to a national standard of service delivery and care, that is in turn sensitive to local needs and variation.

- Agree minimum standards for forensic capture in cases of rape and sexual assault and develop national protocols and paperwork to support these.[6]

- Ensure local/national arrangements are in place for effective clinical governance. All clinicians conducting forensic medical examinations in cases of sexual assault should work within a structure where there is a defined clinical lead, clinical governance framework, clinical supervision, training, continuing professional development, and audit and peer review.[6]

- An enhanced clinical leadership function should be able; provide advice and support on cases to individual FNEs, undertake appraisals and assess CPD requirements, provide personal support to FNEs and signpost to more formal structures where appropriate. In addition they should ensure cases are reviewed, audits are undertaken, as well as oversee quality control standards.[6]

- Establish an information and good practice sharing forum that reflects the professional interests of those working on different parts of the presentation and progression journey for cases of sexual assault.

- 'One size fits all' rape examination kit and protocol often fail to reflect the different evidential issues likely to be at stake when the perpetrator is a stranger or known. Therefore training should ensure examiners are equipped to adapt to these situations, and the established protocols are flexible enough to accommodate difference in circumstance (e.g. in historic cases of abuse).

- Forensic reports should be clear and consistent. Medical examiners should 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.

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6. Appendix 1. Mapping of interventions for women who have experienced sexual assault Country.

	Services for women who have experienced sexual assault
Cyprus	Women can access medical treatment through health care services and the criminal justice system through police services.
Finland	Women can access medical treatment through health care services and the criminal justice system through police services. There are also NGOs that provide support.
Greece	There is a 24 hour phone line for victims of violence against women. There are 12 regional consultation centres offering support to abused women and their children. They can be described as integrated services in that they deal with sexual violence with the context of gender violence.
France	There is a free national rape helpline. In each region there is also a hospital based service known as *les pôles régionaux d'accueil et de prise en charge des victimes de violences sexuelles.* These are centres offering coordinated and specialist services for sexual assault victims.
Ireland	There is a network of 18 Rape Crisis Centres and there are also six dedicated sexual assault treatment units (SATU). These are centres offering coordinated and specialist services for sexual assault victims.
Lithuania	Women can access medical treatment through health care services and the criminal justice system through police services There is a free telephone helpline for women who have experienced violence.
Luxembourg	There is a telephone hotline service that provides 24h assistance for victims of rape and sexual assault. Women can access medical treatment through health care services and the criminal justice system through police services. There is also a standard rape kit for forensic examinations which are performed by court-appointed forensic doctors.

Netherlands	No information identified.
Spain	Some regions have centres offering coordinated and specialist services for sexual assault victims. In other areas women can access medical treatment through health care services and the criminal justice system through police services.
Portugal	No information identified.
Poland	Women can access medical treatment through health care services and the criminal justice system through police services. There are operational procedures for assisting victims of sexual violence which cover medical and psychological support and forensic examination but these are not obligatory.
Romania	Women can access medical treatment through health care services and the criminal justice system through police services.
Slovenia	There is an SOS Help-line, for victims of sexual violence. Women can access medical treatment through health care services and the criminal justice system through police services.
Italy	Women can access medical treatment through health care services and the criminal justice system through police services. There are also anti-Violence Centres are socio-welfare services provided by NGOs. They can be described as integrated services in that they deal with sexual violence with the context of gender violence.
Czech Republic	Women can access medical treatment through health care services and the criminal justice system through police services.
Northern Ireland	There are three rape crime units. These are centres offering coordinated and specialist services for sexual assault victims. There are also a variety of other specialist services including rape crisis centres and helplines provided by government and NGO.
England & Wales	In England there are a range of service providers offering facilities and care for victims of sexual violence which include sexual assault referral

	centres (SARCs). These are centres offering coordinated and specialist services for sexual assault victims. In addition there is a network of Rape Crisis Centres provided by NGOs.
Scotland	There is a dedicated Sexual Assault Service. This is a centre offering coordinated and specialist services for sexual assault victims. There is also a national helpline and 14 rape crisis centres provided by NGOs.
Sweden	There are dedicated sexual assault centres. These are centres offering coordinated and specialist services for sexual assault victims. These are also a range of support services provided by NGOs.
Slovakia	Health care services for women at risk of violence, or women experiencing violence are provided through inpatient care, outpatient care, emergency medical and health services across the Slovak Republic.
Latvia	Health care services are provided in health care settings. A separate forensic service undertakes forensic examinations. NGOs provide counselling.
Belgium	Specialist services exist in some regions but not others. There are also services for police assistance to victims at the local police zones.
Bulgaria	Women can access medical treatment through health care services and the criminal justice system through police services. There is a forensic department. A number of NGOs offer support.
Austria	There are range of specialised services including rape crisis centres. These are coordinated services specialising in sexual assault victims. There is also a 24 hour helpline.
Denmark	There are specialised sexual assault centres based in hospitals. These are centres offering coordinated and specialist services for sexual assault victims.
Switzerland	Medical and sexual health care is provided by health care providers. There are victim support centres in every canton.

Norway	Centres for victims of sexual assault are in place in major towns and cities. These are centres offering coordinated and specialist services for sexual assault victims.
Iceland	There is a specialist Rape Trauma Service. This is a centre offering coordinated and specialist services for sexual assault victims.
Macedonia	Women can access medical treatment through health care services and the criminal justice system through police services. There is an Institute for forensic medicine.
Montenegro	Women can access medical treatment through health care services and the criminal justice system through police services.

Taken from Hardcastle & Bellis (2013) pp. 30-32.

7. Appendix 2 Specific recommendations made to the UK as part of their participation in the COSAI project ((Hardcastle & Bellis, 2013)

Recommendations are grouped into five key themes:

1. Education and awareness-raising

- Education and awareness-raising activities should be implemented to address the current lack of knowledge on specialist sexual assault services among key stakeholders, including healthcare professionals. Healthcare professionals should be trained by those with specialist knowledge and skills (e.g. Sexual Assault Referral Centre [SARC] workers) on how and where to refer victims of sexual assault and, where relevant, learning should be supported by visits to a SARC.

- An understanding of the types of injuries resulting from sexual assault and the possibility of victims presenting with none, some or all of these injuries should be emphasised in the training of those working within the criminal justice system.

- Marketing material raising awareness of specialist sexual assault services should be provided in a wide range of settings where women may disclose sexual violence (e.g. genitourinary medicine clinics, pharmacies, GP surgeries and workplaces) as well as locations such as student services, community centres and licensed premises.

- Awareness raising campaigns for women should focus on the choices available to victims within the SARC pathway (e.g. police involvement or no police involvement, criminal or civil prosecution).

- Education and awareness-raising activities should also focus on potential perpetrators of sexual violence, reinforcing the message that sexual violence is wrong and will be prosecuted by incorporating strong statements from the criminal justice system.

- Consideration should be given to the development of a national database of agencies and services that can assist victims of sexual assault, which would be managed, updated and shared by a central government agency.

- Education in schools should explore gender and relationship issues, address taboos around

2. Standardisation and consistency of service provision

- The wide geographical variation in sexual assault service provision needs to be addressed to ensure that all victims receive consistent high quality care and support. Service provision should therefore be routinely monitored to ensure any gaps in provision are identified.

- Appropriate national guidelines and standards should be developed that: apply to all aspects of service provision; are based on evidence; and are monitored and evaluated by one regulating body. These should detail a clear

care pathway in which SARCs operate as the principle resource centre for all forms of sexual violence (regardless of when the assault took place) and are able to signpost victims and source additional care and support where necessary.

- To extend the consistent delivery of services, consideration could be given to the sub-regional management of specialist sexual assault services in non-SARC settings. Through such a system, established SARCs could co-ordinate provision of specialist sexual assault services via existing services in areas without a SARC.

- Consideration could also be given to establishing regional-level service coordination or leadership that draws on the human resources, skills and expertise of multiple SARCs within a given area. Joint rotas for forensic medical examiners, for example, could limit the deskilling of professionals who may otherwise conduct only a small number of examinations within their direct locality.

- Consideration should be given to the establishment of a Patient's Charter to inform victims of the services and support they can expect following sexual assault.

- Every victim of sexual assault should be assigned an Independent Sexual Violence Advisor (ISVA) to provide support and advice. This requires action to ensure reliable and on-going funding of ISVA services.

- A national helpline should be provided offering 24/7 crisis support and information by trained crisis workers.

3. Improving police and legal services for victims of sexual assault

- Strong partnership working between police and the Crown Prosecution Service (CPS) should be promoted to support the progress of sexual assault cases through the criminal justice system and ensure that victims' needs are balanced against the prosecution process. This may take the form of the co-location of specialist police and CPS staff to provide a joint sexual assault investigation team (e.g. as occurs in Merseyside).

- Consideration should be given to providing all victims of sexual assault with legal advocacy to assist them in progressing through the criminal justice system. Such a system using dedicated legal advocates should be piloted in collaboration with a SARC.

- All police officers and CJS personnel that come into contact with victims of sexual assault should be fully conversant with guidance for the treatment of victims of sexual assault and what support services can be provided. The wellbeing of the victim should remain the primary concern at all times.

4. Research and information sharing

- Anonymous intelligence on sexual assault cases should be shared between partners to enable the identification of trends in assaults and 'hot spots' for sexual violence and facilitate preventive work. For example, the repeat involvement of specific licensed premises in sexual assault cases would enable local partners to engage with premises to improve practice, protect customers and provide information about sexual assault and available services.

- Robust longitudinal research should be implemented as a priority to assess the efficacy of the SARC pathway and identify the cost effectiveness of sexual assault services.

- Research is also required to understand how and when to engage service users in research and service evaluations.

- Over-protective attitudes towards victims of sexual assault can act as barriers to research and evaluation and need to be addressed. Engaging victims in service evaluations will ultimately aid in the improvement and development of sexual assault services in the UK. If victims are not given the opportunity to take part in these evaluations, this could be to the detriment of the care and support that they and other victims receive in future. Victims should therefore be free to make their own choices about participating in research and services that receive public funding to provide sexual assault services should be encouraged to engage in research and evaluation.

5. Special populations

- Special attention should focus on engaging with certain population groups, including sex workers, the lesbian, gay, bisexual and transgender community, foreign students, ethnic minorities, people with disabilities, learning difficulties and mental health issues, and young people. These groups should receive specialist aftercare services, such as specialist ISVAs.

- Important consideration should be given to the needs of 16-18 year olds who can require different care pathways to adult victims.