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Sexual Assault Referral Centres: developing good practice and maximising potentials

Jo Lovett, Linda Regan and Liz Kelly

Child and Woman Abuse Studies Unit London Metropolitan University

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Foreword

In 1998 the Home Office announced the Crime Reduction Programme (CRP), which aimed to develop and implement an integrated approach to reducing crime and making communities safer. As part of this programme, the Violence Against Women Initiative (VAWI) was launched in July 2000, and specifically aimed to find out which approaches and practices were effective in supporting victims and tackling domestic violence, rape and sexual assault. Thirty-four multi-agency victim focused pilot projects were funded and aimed to develop and implement a range of interventions for various population groups in a number of different settings and contexts. The projects were originally funded until the end of March 2002; however, 24 of these projects had their funding, and in some cases their evaluations, extended until the end of March 2003. A further 24 'Second Round ' projects were funded in March 2001; however these were provided with specific service provision funding and were not evaluated by the Home Office.

For evaluation purposes, the projects were divided into nine packages, and projects with similar solutions or strategies, as well as those that were operating in the same contexts, were grouped together. Seven different independent evaluation teams were commissioned to assess the projects in terms of their development, impact, overall costings and cost effectiveness. The findings from all of the evaluations have been collated and a series of research reports and concise practitioner guides are planned for both the domestic violence and rape and sexual assault projects.

This report is one of a series of reports, which specifically reports on the findings from the evaluation of a number of projects, which were funded to support victims in the aftermath of rape. This specific report focuses on the contribution of Sexual Assault Referral Centres (SARCs), and provides a valuable insight into the type of services that are needed to support victims in the aftermath of a traumatic crime such as rape. The findings are timely as many years after the original SARC in Manchester was established, a number of new SARCs have recently been established and several more are in the development stage.

Previously published CRP: Violence Against Women reports

Rape and Sexual Assault

Regan, L., Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault.* Home Office Online Research report 28/04. London: Home Office.

Regan, L., Lovett, J. and Kelly, L. (2004). *Forensic Nursing: An option for improving responses to reported rape and sexual assault.* Home Office Development & Practice Report 31. London: Home Office.

Domestic Violence

Douglas, N., Lilley S.J., Kooper L. and Diamond, A. (2004). *Safety and Justice: sharing personal information in the context of domestic violence - an overview*, Home Office Development and Practice Report 30. London: Home Office.

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Contents

Executive summary

Introduction

- The first Sexual Assault Referral Centre (SARC), St Mary's in Manchester, was established in the UK in 1986, to address serious shortcomings in the medico-legal response to recent rape. Two further SARCs were established in the 1990s, REACH in Northumbria and STAR in West Yorkshire. All three are the subject of this evaluation, funded by the Crime Reduction Programme (CRP) Violence Against Women Initiative.

- Similar models of provision – based in hospitals, ensuring high quality forensic practice combined with crisis intervention and advocacy – can be found in many western countries, including Australia, Canada and the USA.

- Four additional SARCs were founded in the early 2000s, and a further eight will be opened by the autumn of 2004, six of which are part funded by a £300,000 central government investment.

- UK SARCs primarily focus on services needed in the aftermath of recent rape. Support for adults dealing with histories of sexual abuse in childhood, adult rapes that occurred some time ago, sexual harassment and flashing tends to be undertaken by Rape Crisis Centres (RCCs) and Survivors groups, most of which operate on extremely limited and insecure funding.

- SARCs have been highlighted as good practice in several reports, but minimal evaluation has been undertaken to date. The timing of this study, coincides with the largest expansion of statutory services for victims/survivors of rape in contemporary history.

SARCs in context

- The origin of SARCs in the UK, and the arguments for their expansion, turn on a number of widely recognised problems: the low reporting of rape; delays in locating a forensic examiner; lack of female forensic examiners; the environment

in which forensic examinations take place; the manner in which examinations are conducted; inconsistency of evidence gathering; absence of medical follow-up and support; lack of co-ordination between agencies; and limited support services for victims/survivors.

- SARCs were a more expensive and extensive form of provision than that developed in most areas in the late 1980s and early 1990s – rape examination suites and locally recruited teams of forensic doctors.

- St Mary's Sexual Assault Referral Centre is located in a women's hospital and provides an integrated response to adult victims of rape and sexual assault in Greater Manchester. Core services include: forensic and medical examinations; one-to-one counselling; screening for sexually transmitted infections and HIV counselling; prescription of post-coital contraception and pregnancy testing; and 24-hour telephone information and support.

- A Crisis Worker will meet anyone attending the Centre, explain all the processes and ensure informed consent to the forensic examination. Examinations are conducted by a team of forensically trained female examiners. Service users can access other medical and support services if and when required. The CRP Violence Against Women Initiative enabled the piloting of a forensic nursing service, to cover the weekday daytime hours (Regan *et al.*, 2004) and the introduction of proactive re-contacting and advocacy.

- REACH (Rape, Examination, Advice, Counselling and Help) was established in 1991, and has two sites: the Ellis Fraser Centre in Sunderland (in a hospital); and the Rhona Cross Centre in Newcastle (in a house in a residential area), providing services to adult victims/survivors who live in the Northumberland or Tyne and Wear areas. Services and structure are similar to St Mary's, with the exception that there are no Crisis or Support Workers. Through the CRP Violence Against Women Initiative, REACH piloted a website aiming to promote access to the service (Kelly *et al.*, 2004).

- STAR (Surviving Trauma After Rape) is not a centre and does not provide forensic examinations, which are provided by police surgeons in rape examination suites across West Yorkshire. The primary role of STAR is to provide consistent support for victims/survivors of sexual assault across West Yorkshire through its own Initial Support Workers and commissioning

counselling close to where its service users live. STAR was the only SARC to have a Case Tracker who records the progress of any reported rape that is crimed, and keeps the victim/survivor informed about decisions. Through the CRP Violence Against Women Initiative, STAR piloted extending its services to young people (Kelly *et al.*, 2004).

Methodology and data

- The primary research questions were to explore the contribution of SARCs to the experience of reporting rape and/or dealing with its immediate aftermath, and to improving Criminal Justice System (CJS) responses in the light of the increasing justice gap.

- Data were collected from the three SARCs and three Comparison areas in the South East of England selected to reflect a combination of metropolitan, inner city and rural areas, permitting broad comparability with the three SARC sites. The primary comparisons were to be between areas with and without a SARC.

- A multi-methodological strategy was used linking quantitative and qualitative data. The base sample is 3,527 cases, which were tracked prospectively through the CJS. Sub-samples of victims/survivors opted into a series of questionnaires and in-depth interviews (a total of 228 participated). Within this group, police statements and forensic reports were also accessed, where possible. These data were supplemented by expert interviews with key informants and police officers (n=143).

- Whilst this represents the largest data set in the UK literature on rape and sexual assault, there are some limitations to the study. It proved extremely difficult recruiting research participants in the Comparison areas, so more is known about complainants in areas where there is a SARC. It was also the case that details of all reported cases in the Comparison areas were not sent, and final outcome data is only available for two-thirds of the overall sample. The fact that most difficulties were encountered in the Comparison areas suggests that the presence of a SARC increases the possibility of tracking what is happening locally.

Who reports to the police and accesses SARCs

- The vast majority of those using SARCs are female (93%, n=2,936), with an even higher proportion of females reporting to the police in the Comparison areas (97%, n=346). Men appear more likely to report rape where there is a SARC. The majority of those reporting rape are under 35-years-old, and this proportion is even higher in SARC areas.

- In contrast Black and minority ethnic victims/survivors were most evident in the Comparison areas, where they represented a third (34%, n=120) of complainants. This is partly explained by the demography of two of the Comparison areas. However, in none of the areas was the level of reporting by these groups equivalent to their representation within the local population. Both St Mary's and REACH worked with a number of female asylum seekers (primarily from African countries) who had suffered sexual violence in their countries of origin.

- A significant minority (5%, n=193) of the case-tracking sample had a disability, most commonly with mental health or learning disabilities. This may indicate vulnerability to sexual assault among these groups.

- Women known to be involved in prostitution were evident, especially in the St Mary's and STAR areas (2%, n=31, and 3%, n=31 respectively). The majority of these cases were police referrals.

- The majority of SARC referrals were from the police (68%, n=2,161), although almost a quarter were self-referrals, especially at REACH and St Mary's. REACH and STAR also receive a proportion of referrals from other sources. SARCs, therefore, can be said to increase access to services in the aftermath of rape.

- The overwhelming majority of perpetrators were male (over 99%, n=3,510 across all sites), with the majority being single perpetrator assaults (91%, n=3,199). Strangers accounted for between a fifth and a third of perpetrators across all sites. Assaults by known men were more common amongst self referrals than police referrals (73%, n=488 compared to 58%, n=1,216), confirming that rapes by known men are still less likely to be reported to the police.

- SARCs undoubtedly increase access to services and support for a proportion of those who do not report rape to the police.

- Few self-referrals currently convert into police referrals, but there may be space for sharing information with the police for intelligence purposes, where service users agree.

Forensic and medical services

- Previous research has highlighted the following as good practice: a female examiner; privacy; a non-institutional setting; respect and sensitivity; being talked through, and having some control over, the process.

- Two broad forms of service delivery were assessed: an 'integrated' model where forensic examinations were conducted on SARC premises (St Mary's and REACH); and an 'outsourced' model. There were two variations of the latter: one where examinations took place in examination suites and were conducted by a team of forensic examiners to which the police officers have immediate access (Thames Valley); the other where provision is contracted out to a third party (STAR, Brent and Newham).

- On a variety of measures service users rated the environment and conduct of the forensic examiner in integrated models highest. These views were also echoed by police officers.

- A higher proportion of cases resulted in examinations in SARC areas, especially where there was an integrated model.

- Service users, both female and male, expressed a strong preference for female examiners: this should be the default position.

- In all areas there were still long waits for an examination, although this was addressed somewhat in Greater Manchester through the introduction of a forensic nurse examiner.

- Overall the two integrated SARCs were the most reliable in providing prompt and consistent responses. The outsourced model where third parties co-ordinated provision of forensic examinations performed least well.

Support, advocacy and counselling

- A range of immediate, short and longer-term support options were provided by the SARCs. In the immediate period after an assault, St Mary's ensured all victims/survivors had contact with a Crisis Worker. In the following weeks service users might access an Initial Support Worker (ISW) and/or Case Tracker at STAR, and the newly-instituted Support Worker at St Mary's. All the SARCs also offered out-of-hours telephone contact and counselling.

- No similar services existed in the Comparison areas, and here a considerable amount of responsibility for 'victim care' fell to specially trained police officers. It was therefore not possible to compare take-up of services between areas with and without a SARC.

- The Crisis Workers at St Mary's received the highest approval rating of any support staff assessed by service users, and their presence may account for the higher proportion of forensic examinations undertaken at St Mary's.

- ISWs provide six sessions of flexible support post assault. They are all volunteers, and are recruited to ensure as close a geographical and demographic 'fit' as possible between STAR services and service users. It is an 'opt in' service and there was a relatively low take-up, partly due to problems of availability. The majority of users valued this service highly, but there was some variation in their assessments.

- For those who used it, the Case Tracker appeared to overcome the frequently noted problem of victims not being kept informed about progress and decisions in a legal case.

- The Support Worker represented a radical departure from previous practice, in so far as it was a routine, proactive follow-up model, rather than the 'opt in' model characteristic not only of SARCs but also of RCCs and Victim Support responses to rape/sexual assault.

- Implementation of this service was complex, due to the philosophical challenge it represented to previous practice.

- Once it became embedded, however, the intervention revealed hitherto unmet practical support and advocacy needs, and the evaluation demonstrated that victims/survivors welcomed the proactive contact.

- A higher proportion of service users made use of the Support Worker than accessed counselling in the immediate aftermath of an assault. Where a legal case was proceeding, a lower proportion of those contacted twice or more by the Support Worker withdrew from the CJS. These findings suggest that flexible support and advocacy are the most vital support functions SARCs should embrace.

- Counselling was accessed by between a third and two-thirds of SARC users. Most research participants who did so valued it, and a proportion noted that it should not be time limited.

- Across all forms of support a majority expressed a preference for female staff.

- The data from St Mary's offer strong support for moving towards proactive models, in which the SARC takes responsibility for initiating and maintaining contact. Overall, flexible access to support and information about case progress were identified as primary needs.

- SARCs should attempt to offer the widest range of options possible, across three broad themes: initial crisis support; informal support and advocacy; and longer-term 'therapeutic' work.

Do SARCs make a difference?

- The two integrated SARCs were described as 'safe', 'reassuring' and 'private' locations.

- Whilst access to SARCs is highest in the first six months, a fifth of service users were still in contact almost a year later. The vast majority rated contact positively.

- The most common reason SARC users gave for discontinuing contact was 'wanting to forget'. A proportion of this group will undoubtedly seek support at a later date, often using organisations like Rape Crisis.

- The primary source, and route to other support, for those in the Comparison areas were the specialist police officers. Whilst there were only a small number of research participants in these areas, far less support was accessed, and much higher unmet needs were evident.

- Whilst SARCs are inter-agency projects, wider multi-agency work on sexual assault was minimal, although it was enhanced by case advocacy.

- The two SARCs with integrated forensic services were most able to conduct this sensitive process in ways that respected the complainant's dignity, and displayed more consistently good practice.

- The levels of service use evident at the three SARCs suggest they encourage take-up of support in the aftermath of rape and sexual assault in a significant number of cases, and more victims/survivors are able to access this due to the possibility of self-referral.

- Service users valued SARCs extremely highly and many made use of a range of services. Areas that were particularly appreciated included: automatic provision of female examiners and support staff; proactive follow-up support; case tracking; advocacy; and easy access through the telephone to advice and information. However, there were requests for greater out-of-hours access, more support groups and self-defence classes.

Future potentials and an 'ideal' SARC

- The assessments of service users, and the unmet support needs they identified, made clear that the emphasis in SARCs needs to shift to a more flexible, practical support, information and advocacy service with a proactive approach.

- There is potential to increase reporting and develop more integrated models of forensic examinations with respect to child sexual abuse and domestic violence, especially in areas where the numbers of rapes per annum would not justify a SARC.

- Where a move to provide integrated services is made, the challenge is to combine this with specialisation and innovation.

- A SARC should seek to provide a unified continuum of care to those who have recently suffered sexual violence.

- An 'ideal' model is presented covering: the overall framework; range of services; forensic practice; and inter-agency links. This can be applied to existing SARCs, new or developing ones, as well as to areas where there is no SARC or planned development so as to audit current provision and set priorities for year on year improvements.

- The extent to which SARCs can develop and achieve consistent good practice will partly depend on a strong steer from government to create national protocols and standards. The newly formed Inter-Ministerial group on Sexual Violence is ideally placed to provide this.

1. Introduction

Sexual Assault Referral Centres (SARCs) emerged as one way, in the immediate aftermath of rape, to meet the needs of victims/survivors[1] and the criminal justice system simultaneously. Many of their features reflect attempts to address criticisms of existing provision. In the UK, for example, the first SARC followed the national debate in the wake of the now infamous television programme featuring Thames Valley police[2] (Gregory and Lees, 1999): St Mary's Sexual Assault Referral Centre was established in Manchester in 1986. Progress since then has been halting, with REACH in Northumbria and STAR[3] in West Yorkshire opening in the early 1990s. All three of these pioneering groups are included in this study, alongside three Comparison areas where there is no SARC. Between 2000 and 2003 four new SARCs have been established, most since the evaluation was underway: Juniper Lodge in Leicester in 1999; The Haven, in London in 2000; The Sanctuary in Swindon in 2001; and the SAFE Centre in Preston in 2002. As the research was being completed funding was secured for two additional Havens creating pan-London coverage by spring 2004. In addition, as part of the Action Plan developed from Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) (2002) audit on the investigation and prosecution of rape, the government announced £300,000 to encourage the development of SARCs, and almost simultaneously a bid was submitted for a SARC in Glasgow. Six groups were successful in tendering for the Home Office investment, and have committed to opening a SARC by autumn 2004: Derbyshire; Cambridgeshire; Hampshire; Kent; West Mercia; and West Midlands. Plans are also well underway in at least three other areas. This report, assessing current provision and good practice within three existing SARCs and reflecting on their future potentials, is timely given the current and likely future expansion of SARCs in the UK.

SARCs in context

The health sector has been a prime mover in providing sexual assault services in other countries. Provision similar to SARCs is the norm in North America, with most being hospital-based, although there are peripatetic models – developed with teams of forensic nurses in mobile units in some areas of the USA, and models adapted for remote areas

1 The debate about the most appropriate term to refer to anyone who has been subjected to sexual violence is noted (see Kelly *et al.*, 1996). Both terms are used in this report, alongside 'complainants' and 'service users'.

2 This was Roger Graef's A Complaint of Rape (1982).

3 STAR does not refer to itself as a SARC, since it is not 'centre'-based. However, it has the most effective 'referral' process of the three organisations. For ease of reading, and because the term SARC is increasingly recognised, all three are included under this generic category.

relying on trained forensic nurses (see, Kelly, forthcoming). In Canada and the USA the models primarily involve crisis intervention and forensic examinations, with formal links to community-based advocacy and counselling services, often run by the equivalent of Rape Crisis Centres (RCCs). For instance, one of the models considered an example of promising practice in the USA is co-ordinated in New York by a Rape Crisis Centre (Kelly, forthcoming). The extent of provision, compared to the UK, can be seen through the example of the province of Toronto, where there are 70 SACs (Sexual Assault Centres) (Kelly, forthcoming). Equally, in the USA funding under the Violence Against Women Act has promoted the development of forensic nursing across the country, and now under the STOP[4] Violence Against Women Programme, building co-ordinated community responses to sexual assault is a new priority. The emphasis in Australia has been more community-based, with Sexual Assault Services funded through health budgets but located outside hospitals, with the centre often close to, or even within hospital grounds (*op cit*). The provision of forensic examinations seems more consistent where Centres/Services are located within a hospital.

Developments in the UK have been an amalgam of these models, being primarily hospital-based, but with an emphasis on counselling rather than advocacy. Current SARC services consist primarily of: crisis intervention with respect to recent sexual assault; ensuring professional standards and the prompt availability of forensic examinations; providing immediate medical care and follow-up tests; and short-term counselling. This report will demonstrate, however, that there are variations and new developments in UK SARCs. Support for adults dealing with histories of sexual abuse in childhood and adult rapes that occurred some time ago, as well as other forms of sexual violence like sexual harassment and flashing, tends to be undertaken by RCCs and Survivors groups, most of which operate on extremely limited and insecure funding.

4 STOP stands for Services, Training, Officers and Prosecutors. The funding programme under successive implementations of the Violence Against Women Act is directed to improving Criminal Justice responses, and has steered the development of what are referred to as 'promising practices' for over a decade. Current STOP funds (which have to be matched by local areas) are allocated: 25 per cent to law enforcement; 25 per cent to prosecution; five per cent to courts and 30 per cent to victim services. (For more details see www.ojp.usdoj.gov/vawo and http://toolkit.ncjrs.org/default.htm.)

Inauspicious beginnings

The establishment of the first SARCs was not without controversy, and tensions were most obvious with the Rape Crisis movement (Foley, 1996; Skinner, 2000). The major points of contention at the time were: a lack of consultation about the new services; fears about rape being 'medicalised'; concern that women would be pressured to report to the police; and that the foundational work of the Rape Crisis movement in understanding and advocating for the needs of women who had been raped would be eclipsed. Marian Foley wryly recalls the early perceptions:

> *At that time we were clear that SACs were a potential threat to the future existence of feminist RCCs. The threat never really materialised and SACs have never (to date) really taken off in Britain.*
>
> (1996, p166)

Almost a decade later the picture is somewhat different, with SARCs identified as good practice in a number of reports (Commission on Women and the Criminal Justice System, 2003; HMCPSI, 2002; Women's Unit, 1999) and a significant growth in provision in the last three years compared to the previous decade. In the intervening time it is increasingly evident that the practice of existing SARCs has explicitly and implicitly drawn on feminist perspectives, and in most areas there is dialogue, and in some cases strong working links, with local RCCs[5]. These shifts are the outcome of many factors, not least: the recognition of the role of partnership and inter-agency working (despite its limitations); research findings that confirm many of the insights and principles of feminist practice; and the increasing numbers of women and men who are reporting rape. In 2004 it is unlikely that any SARC would be planned without including local specialist services, and especially RCCs, in its development.

The Crime Reduction Programme's (CRP's) Violence Against Women Initiative has provided a unique opportunity to examine the contribution of SARCs to responses to reported rape and sexual assault, since under its auspices interventions have been funded at the three original projects – St Mary's, REACH and STAR. They are linked not only through their specialist provision of services to victims of rape and sexual assault, but also by virtue of their participation in the Initiative.

5 This varies primarily because some areas do not have Rape Crisis Centres, and in a number of locations the local service is so underfunded that the level of service they are able to provide is extremely limited.

Structure of report

In this report the development of SARCs, the current services provided by St Mary's, REACH and STAR and their CRP-funded initiatives are outlined. The methodology and data on which the report is based are also outlined. Data is then drawn on to assess the range of services and ways in which they are provided across the three SARCs and three Comparison areas focusing on: access to services; forensic examination; follow-up medical services; support, advocacy and counselling. Data is also used to explore what professionals and service users think about SARCs, and the report concludes with a brief discussion of cost effectiveness, an outline of future potentials and a model for an 'ideal' SARC.

2. The emergence and development of SARCs in the UK

The establishment of St Mary's, REACH and STAR drew on a number of recurring criticisms of police responses to rape victims (see Women's National Commission, 1985; Smith, 1989). These included:

- low reporting of rape;
- delays in locating a forensic doctor;
- lack of female forensic doctors;
- the environment in which forensic examinations took place;
- the manner in which examinations were conducted;
- inconsistency of evidence gathering;
- absence of medical follow-up and support;
- lack of co-ordination between agencies;
- limited support services for victims/survivors.

Many of these elements require medically trained staff, and involve tasks which other service providers – like RCCs – could not nor would want to provide. The inconsistency in access to forensic medical examiners and poor standards of premises in which such exams were conducted have long been noted, and SARCs were a more expensive and extensive form of provision than that which developed in most areas in the late 1980s and early 1990s – rape examination suites and locally recruited teams of forensic doctors[6]. In all areas where subsequent audits of the suites have been undertaken a poor standard of maintenance and quality has been noted (see, HMCPSI, 2002; Metropolitan Police Authority, 2002; Gregory and Lees, 1999). We still lack national standards for examinations, or a form that all forensic medical examiners use. Inconsistency, therefore, continues to be the order of the day across much of the UK. This contrasts sharply with the aspirations in both the Victim's Charter (first published in 1990 and revised in 1996) and the more recent Home Office programme of work on Vulnerable and Intimidated Witnesses to ensure victims/witnesses are provided with consistent and high quality responses and are kept informed about the progress of the case.

6 This is the nature of current provision in the Comparison areas, although forensic examiners are engaged by a contractor in Brent and Newham. (See discussion of Comparison areas in Chapter 3 below.)

Three SARCs: history and current services

The development of SARCs began in the UK in 1986 when Greater Manchester Police (GMP) and Central Manchester Health Authority launched the St Mary's Centre. REACH, was established in 1991, followed by STAR in 1994. The current structure, staffing, funding and services provided by the three organisations are outlined below.

St Mary's

St Mary's in Manchester has, to a significant extent, been the template for SARCs in the UK[7], partly facilitated by their *Promoting the Model* conference in 1999. It is located in a women's hospital and provides an integrated response to adult[8] victims of rape and sexual assault in Greater Manchester. Core services include: forensic and medical examinations; one-to-one counselling; screening for sexually transmitted infections and HIV counselling; prescription of post-coital contraception and pregnancy testing; and 24-hour telephone information and support. The majority of referrals are from Greater Manchester Police, although self-referral is possible. St Mary's has two suites of rooms: one close to the hospital reception area, which is where forensic examinations are conducted; and one on another floor where the staff offices and counselling rooms are located. The CRP Violence Against Women Initiative enhanced service provision through a forensic nurse who conducted most weekday daytime examinations and introducing a proactive re-contacting and advocacy service (provided by a full-time Support Worker), which included the possibility of the Support Worker being present during police statement taking (see Chapter 6).

The counselling and self-referral systems operate primarily during office hours, although anyone presenting who has been recently raped can access the emergency services. Where a report is made to the police, a phone call is made to the Centre and from there the team can be gathered, out-of-hours using an on-call system. Once at St Mary's, the service user is met by a Crisis Worker whose role is to provide the victim with immediate crisis support and information from the point of arrival to when the examination has been completed. She explains the medical and legal context; during this period the forensic examiner prepares the examination room and the police officer provides him/her with a brief synopsis of what he/she knows about the assault. No examination takes place without the consent of the service user. With the exception of the police role the processes are the same for self-referrals. All such service users who have been

7 It has had a wider influence than this with a service based on it established in Sierre Leone and the 'one-stop shop' model in Malaysia adapted from it. The latter has been promoted across South East Asia (see Kelly, forthcoming).

8 As later data will demonstrate a number of adolescents are also attendees at St Mary's.

recently assaulted are given the option of having a complete examination and storing the samples securely at the Centre until such time as they decide that they should be handed over to the police, or, at their request, destroyed. Practice in relation to forensic examinations is that, unless otherwise requested, they are conducted by women and at the pace of the victim/survivor (Regan *et al.*, 2004). At the end of the examination a debriefing session takes place with the Crisis Worker, where additional St Mary's services are outlined. Since the appointment of the Support Worker all attendees are re-contacted the next working day; she offers both to attend the statement-taking (if it has not already been done) and to facilitate access both to St Mary's services and other external organisations. Proactive follow-up is also part of the Support Worker's role (see Chapter 6). Counselling is available, and there is no limit set on the number of sessions. St Mary's also operates an open advice, information and referral service through the telephone, including an 'out-of-hours' service.

The current staff team consists of a project manager, a clinical director, five sessional Crisis Workers, two full-time counsellors, one Support Worker, 12 sessional forensic doctors, an administrator and, as of March 2003, a research and development officer. Since January 2004 the forensic nurse post has been covered by two part-time forensic nurses.

REACH

Northumbria Police and the Women Doctors' Scheme established REACH in 1991. The latter grew out of a campaign by the local RCC, and at the time was considered a model of good practice in ensuring access to female forensic examiners. Whilst centre-based, there are two separate locations: the Ellis Fraser Centre in Sunderland (in a hospital); and the Rhona Cross Centre in Newcastle (a house in a residential area). A police and self-referral model operates for adult victims/survivors who live in the Northumberland or Tyne and Wear areas and current services comprise: forensic examination; medical services and follow-up; and counselling. Procedures are similar to those for St Mary's, with the exception that the role of the Crisis Worker has to be fulfilled by a combination of a specialist police officer[9] and the forensic doctor. Counselling services at REACH are limited to a set number of ten sessions, although there is some flexibility in individual cases. REACH also offers group counselling in some cases, and is the only SARC to do so currently[10].

9 Specialist officers are used in all areas but St Mary's, with varying titles: SOLOs (Sexual Offence Liaison Officers) in the REACH area; RVLOs (Rape Victim Liaison Officers) in the STAR area; and SOITs (Sexual Offences Investigative Techniques officers) and chaperones in the Comparison areas. Their role is to support the complainant from the report to an eventual trial, but is distinct from an investigative one.

10 This is only offered by some Rape Crisis services and is not available through Victim Support.

REACH funding comes principally from four local Health Authorities (Northumberland, Sunderland, Gateshead and South Tyneside, and Newcastle and North Tyneside), together with the Northumbria Police Authority. The staff team consists of a full-time manager, four part-time counsellors and a part-time support clerk. Recently, REACH has begun piloting a case- tracking service. Under the CRP Violence Against Women Initiative, REACH received funding to design and develop a website, with the aim of extending awareness of the service and increasing access for potential service users. Their bid also involved a pilot of videoing evidence-in-chief for adults, though the delayed implementation of the section of the Youth Justice and Criminal Evidence Act that made such evidence admissible, meant this part of the REACH project could not be operationalised.

STAR

STAR differs significantly from the other two SARCs: it is not a centre and does not conduct forensic medical examinations. These are provided by police surgeons in rape examination suites across West Yorkshire. Throughout the evaluation period these services were contracted out to an organisation called Healthcall, and since summer 2003 have been organised by Primecare. The decision to create an alternative model was based on the geography and size of West Yorkshire, which includes large cities like Leeds and Bradford, as well as small towns and villages and large rural areas. The primary aim of STAR was to provide consistent support for victims/survivors of sexual assault across the region; its primary role, therefore, has been to co-ordinate and commission local support and counselling for adults, and also offer immediate support and advice through a helpline. Counselling is commissioned from accredited counsellors, who are responsible for making arrangements with service users about the location and timing of sessions. The rationale here is that this enables access close to where service users live. A maximum of ten sessions will be paid for by STAR for any service user. Two innovative elements of the STAR model are Initial Support Workers and the Case Tracker. Initial Support Workers are volunteers, trained by STAR, who offer immediate crisis support for six weeks – this may be practical, access to information, as well as just someone to talk to. The preferred model is for service users to move from this more informal support into counselling. The Case Tracker's role is to follow the progress of any reported rape that is crimed, and keep the victim/survivor informed about decisions. This involves liaison with the police, courts and on occasion the Crown Prosecution Service. In addition, the Case Tracker also monitors the Crime Report Information System (CRIS) police case printouts to check for any reported rape cases that have not been referred to STAR. Lack of referral is then checked – whether it was because the complainant declined contact, or due to an oversight.

Under the CRP Violence Against Women Initiative, STAR extended all its services to young people aged between 14 and 16: this group comprise a significant proportion of those reporting rape, yet fall between child and adult services.

STAR is jointly funded by West Yorkshire Police Authority and the four local Health Authorities (Bradford, Kirklees and Calderdale, Leeds and Wakefield). The current staff team consists of a project manager, a co-ordinator (responsible for recruitment, training and office and evaluation management), a Case Tracker, a referral co-ordinator (responsible for running the helpline and run as a job-shared post), a publicity officer and an administrator, as well as 27 volunteer Initial Support Workers and 35 sessional counsellors.

All of the more recently established SARCs are centre-based, and focus on the core services of forensic examination, medical services and counselling. In Chapters 4 to 7, data is drawn on to show the contribution of SARCs to the experience of reporting rape and/or dealing with its immediate aftermath.

3. Methodology and data

Research questions

Unlike the evaluations of the funded interventions at St Mary's, REACH and STAR, this national evaluation of SARCs was not tied to extending service provision. Rather, it aimed to build on the individual evaluations at the three sites in order to examine the broader contribution of such services to the process of reporting rape. The evaluation also took place amid a context of growing concerns about attrition and the justice gap (and increasing interest in the SARC model of response) – this issue is dealt with in a separate publication (Kelly *et al.*, 2004).

The central questions for the research were:

- How do these different variations of SARCs provide services?
- Do St Mary's, STAR and REACH deliver a speedy and effective service to victims of rape that treats them with dignity and respect?
- Is there a consistent standard of evidence gathering and forensic reports?
- Does the provision of counselling encourage take-up of follow-up support in the aftermath of sexual assault?
- Do these services cater for the needs of victims/survivors?
- Is there a significant difference between responses to victims/survivors in these areas compared to an area with no such service?
- Is co-ordination between agencies enhanced in areas where there is a SARC?
- Do SARCs increase reporting and reduce attrition?[11]

Comparison areas

Assessing the contribution of SARCs also required comparing them with other models of service provision; therefore an element of the evaluation design was the inclusion of a Comparison group drawn from areas where there was no SARC. Three sites in the South East of England were selected to create a sample that would include a combination of metropolitan, inner city and rural areas, thus permitting broad comparability with the three SARC sites, although it is impossible to make direct comparisons since no two areas in the UK are identical. In addition, as the three SARCs serve large populations, it would have been difficult to replicate this size for

11 This issue is addressed in a separate publication (Home Office, 2004).

the comparisons without having to engage and negotiate with multiple police areas.[12] Indeed, one of the important roles of a SARC is that it can act as a central focus for information. A comparative profile of all six areas is presented in Appendix 1. The successful recruitment of Comparison areas was also dependant on the co-operation of senior police officers within them, so force areas where we had existing contacts were initially approached.

Originally two areas within the Metropolitan Police force area, Brent and Newham, were engaged. In both, dedicated teams of officers (SOITs) trained in dealing with victims of sexual offences are based in police stations. Both sites are located in densely populated, urban areas with a mixed ethnic profile. To ensure greater comparability with the SARC areas a third site, Thames Valley, was also included. Here, too, there are specialist officers (chaperones) but at the start of the evaluation they were linked with the Child Protection Unit. Latterly, this became a joint Child Protection and Sexual Crime Unit. The area covers a wide range of urban and rural locations, with a less mixed ethnic profile than the two London sites. There are very limited specialist services in all three areas. In Brent and Newham forensic services are performed by a contractor (Healthcall) and in Thames Valley by a locally co-ordinated pool of forensic examiners; forensic examinations are conducted in rape examination suites in a range of locations. While officers provide information on Victim Support and counselling services, there is no co-ordinated provision of support for complainants or a direct referral system at any of the three sites. Moreover, referral to Victim Support is not automatic but only takes place where police officers ask complainants if they wish to receive contact and the referral to Victim Support followed through.[13] Police officers have no record of whether any individual complainant accesses any form of support from any external agency, including Victim Support.

Methodology

A multi-methodological strategy was used linking quantitative and qualitative data. The total *data corpus* is presented in Table 1[14] and a full description of the research tools and data sources can be found in Appendix 2.

12 Two of the Comparison sites are in the area covered by Project Sapphire, the Metropolitan Police's strategic response to reported rape. However this was launched in January 2001, and only began serious case-tracking at the end of 2003, well after the evaluation had been conceived and the methodology designed.

13 This is in line with current Home Office recommended practice (see Home Office Circular 44/2001, http://www.homeoffice.gov.uk/docs/hoc44.html).

14 Agreement about research tools and protocols took varying lengths of times across the six sites, resulting in differences in the lengths of time data were collected: at St Mary's from 1October 2000 to 31December 2002 (27 months); at STAR and REACH from 1January 2001 to 31December 2002 (24 months); in the Comparison areas from 1 August 2001 to 31 December 2002 (17 months). Although no data on new cases were collected beyond 31 December 2002, outstanding data collection, such as interviews and tracking case outcomes, did continue at all sites into 2003.

Table 3.1: Total data collected for the national evaluation

Data source	St Mary's	REACH	STAR	Comparison	Total	Original projected total
Cases tracked prospectively	1,442	638	1,092	355	**3,527**	**2,000**
Police *pro forma* 1	889	337	836[1]	349	**2,411**	
Police *pro forma* 2	686	271	836	291	**2,084**	
Service user data						
Questionnaire 1	66	51	91	20	**228**	**250**
Questionnaire 2	23	32	59	11	**125**	**130**
Questionnaire 3	20	22	36	7	**87**	**100**
In-depth interviews	12	17	20	7	**56**	**80**
Witness statements	31	0	19	0	**50**	**100**
Forensic medical reports	100	0	9	0	**109**	**130**
Interviews with staff and key informants	48[2]	20[3]	42[4]	26[5]	**136[6]**	**43**

Notes 1.All STAR cases reported to the police, data downloaded from STAR project database.
2.34 individuals.
3.20 individuals.
4.39 individuals.
5.26 individuals.
6.120 individuals.

A database was designed for the project in order to conduct the prospective case tracking – the first such extensive attempt in the UK literature on rape. Details of all cases seen by the SARCs over the time periods, including police and self-referrals, were entered, as well as all those where *pro formas* were completed in the Comparison areas. Fields covered: demographic data; basic case details; take-up of services; and outcome of the legal case, where a report to the police had been made. This 'case-tracking sample' was the overall pool from which all other data relating to service users were drawn, with questionnaire respondents, service user interviewees, forensic medical forms and witness statements forming subsamples within it.

All questionnaires and interview guides had a common core, but were then adapted to reflect the different procedures and services in each of the SARCs and the Comparison areas. Whilst this made data coding and analysis more complex, any other approach would have failed to address the variation in services provided by the SARCs.

Complex procedures were negotiated with each SARC and the Comparison areas to invite service users to participate in the research. Once consent was forthcoming, questionnaires were sent at three points in time after initial contact over the period of a year. The first questionnaire covered the decision to report or not, experience of the initial police investigation and intentions regarding pursuit of any legal case and future service use. The second and third were shorter, and questions were limited to case progress and current and intended use of support services. Respondents were given the option of completing the questionnaire by hand and returning by post, or over the telephone with a researcher, and were also invited to take part in an interview. In-depth interviews with those who agreed to one were undertaken at the SARC, the home of the individual or by telephone. Comparisons have been conducted across the case-tracking sample and the questionnaire and interview participants. Service users who volunteered to take part in the study were broadly similar to the case-tracking sample across most variables with the following exceptions: less Black and minority ethnic service users took part; on average participants were slightly older; and they were more likely to have cases proceed through all layers of the CJS.[15]

Interviews with professionals and key informants (SARC staff and counsellors, forensic examiners and management committee members, police officers, prosecutors and other support services) explored their perspectives on local responses to rape and sexual assault.[16] In addition, an audit of a sample of forensic medical reports and content analysis of a sample of witness statements was undertaken.

In the presentation of data in this report the prospective case-tracking sample forms the main data set. All other data relating to each case (questionnaires and interviews with service users, police *pro formas*, forensic medical forms and police statements) are linked to this through a unique reference number. Analysis of the prospective case-tracking data consisted primarily of basic frequency counts and cross-tabulations using the Access database package. Questionnaire data were entered onto SPSS for Windows and, where appropriate, statistical significance tests (Chi-square) were conducted. In addition, all responses to open-ended questions were typed into text files related to each question. These were then grouped thematically and coded for frequency of responses. Interview data were analysed using a similar process of 'consolidation' – collecting all responses to particular questions in a single text file, undertaking coding and content analysis to reveal areas of similarity and difference and conducting frequency counts. Where appropriate, numbers and percentages of interview respondents who expressed particular views and opinions are reported on.

15 Given that almost all volunteered to take part within six weeks of reporting this is an interesting and unexpected finding which is further explored in (Kelly *et al.*, 2004).

16 Initial interviews with REACH staff were done by Rosemary Barbaret and interviews with police in that area by Helen Taylor. Interviews with staff and key informants in the STAR area were conducted by Tina Skinner and Helen Taylor. In some cases more than one interview was conducted with the same person; where this is the case quotes are followed by the date of the interview.

Limitations

Table 3.1 also compares actual data collected to that projected in the original application. In some fields the anticipated totals were exceeded, such as the numbers in the case-tracking database and the interviews with staff and key informants. In others the targets were not reached, especially with respect to forensic reports, police statements and interviews with complainants. In relation to the forensic reports and police statements, the procedures requiring initial consent from complainants, and, in the case of all sites apart from St Mary's, with Health Trusts and then individual forensic examiners, created conditions that proved virtually impossible to fulfil.

Although a higher than anticipated number of cases was recorded on the case-tracking database, gaining access to all cases reported in the Comparison areas proved unachievable, as two key problems consistently affected the provision of data. Firstly, officers here did not share a sense of 'ownership' of the evaluation to the same degree as project staff at the SARCs. Whilst there was a recognition of the importance and potential benefits of the study from senior officers in all three areas, for individual officers on the ground – those who effectively supplied the necessary data – the study requirements undoubtedly represented yet another demand on already pressured workloads. Secondly, circumstances, and in some cases general practice, gave rise to frequent staff changes in all the police areas we collaborated with.[17] While significant amounts of missing case-tracking data were eventually recovered, the total number of cases we were given details of, falls short of the total number of reports in each area, and the number of complainants invited to participate in the research was also lower than hoped for. This led to the decision to group together cases from all three Comparison areas when conducting comparative analysis between the SARC and non-SARC sites.

Considerable time also had to be devoted to updating case outcomes (using *pro formas* to the police at two points in time, within a couple of months of the report and approximately a year afterwards, in all areas except STAR, where these data were extracted from their case-tracking database), and especially getting returns from the Comparison areas. Whilst outcomes have been entered for over two-thirds of the whole sample, it proved impossible to access data for a significant proportion, despite support from senior police officers and the research team producing charts and individual case sheets indicating missing data on several occasions. This is obviously a limitation of the study, highlighting the difficulties of prospective research across multiple sites.

17 In each of the three Comparison areas the link police officer changed three times during the project, and in only one case was there a handover process.

The lack of support service provision, and of any recording of take-up, in the Comparison areas also meant that it was not possible to conduct quantitative analysis of access to support in these areas. It was impossible, therefore, to compare support service take-up between the SARC sites and the Comparison areas. Consequently, the qualitative data provided by the small number of respondents in the Comparison areas who completed questionnaires and interviews to assess service use had to be relied upon.

Engaging individuals who have recently experienced rape in research is a sensitive process, and one beset by a range of hurdles, including the fact that some move without a forwarding address, and researchers invariably having to negotiate with various 'gatekeepers' who often take decisions for survivors (see also Jordan, 2001) – for example, deciding that they should not be informed about the research because they are too vulnerable. The lower than expected participation is partly due to low recruitment from the Comparison areas, where researchers were reliant on specialist police officers who had relatively little investment in the research outcomes, and thus did not prioritise ensuring victims/survivors were made aware of the study. In addition, this conduit of the police as the initial contact point may have deterred those who were unhappy with the police response. The issues with SARCs are rather different, and offer insight for future research. The three SARCs recommended different start dates for making an initial approach about participation, and these were experimented with during the evaluation. There were higher participation rates from the two SARCs where the letter from the research team was not sent until at least a month after initial attendance (see Appendix 3 for response rates at all sites).

Both the questionnaires and interview schedules for victims/survivors included explicit questions on participation: no one reported that it had been damaging or negative overall, but just under a third (n=55 from Q1, reducing to a fifth for Q2 and Q3) noted that the process had been 'difficult'. Many reported positive motivations for participating, primarily to help others, inform policy and practice development and provide feedback on positive experiences of services. Interestingly, one of the most common free text comments referred to a sense of being 'listened to', and by the third questionnaire more than a fifth of respondents (n=17) referred to the research process as having been 'illuminating' for them. These data suggest that victims/survivors are able to make informed choices in deciding whether to participate in research, and that a proportion welcome the opportunity to have their views and experiences recorded.

When she [REACH staff member] *mentioned it, about there was going to be some research … she says "You don't have to," and then I got a letter and I says "Oh yes I would because as I say they've helped me so much, and if what I can say can help anybody else in the situation"…* [If] *one sentence I say makes a difference to somebody else, then that's the reason I wanted to do it*

(REACH, service user, Interview 13, Guilty plea).

The questionnaires, I think they actually really helped when I was getting them, 'cause… it's kind of like somebody was listening to me, taking me into consideration, and I felt that those questionnaires actually did really help me

(STAR, service user, Interview 14, Conviction).

I'm glad that something like this has come about, that there's ladies like you helping us victims, because nobody seems to understand us. And you seem to understand us... I mean, nobody wants to know. And the feeling is [it's] *done with, that's it, it's over with. And you're forgotten… At first I was a bit nervous of filling them in, what to say and how to say it, or how to put it down on paper… The questionnaires were fine, I understood them… There was questions that the police didn't ask us, that you put down there, which was good. So, yeah, I felt comfortable… I was happy doing it*

(Comparison, Interview 4, Undetected).

Whilst there are limitations to this data set, it nonetheless represents the largest in contemporary rape research in the UK, and even the numbers of victims/survivors taking part exceeds other studies quite markedly (see, for example, Lees and Gregory, 1993; Harris and Grace, 1999; Temkin, 1999).

4. Who accesses SARCs and reports to the police

Drawing on the case-tracking database the following similarities and differences across the samples emerged. Full comparative analysis across the SARC and Comparison areas of the variables discussed below is presented in Appendix 4.

- The vast majority of those using SARCs are female (93%, n=2,936 across all three), with an even higher proportion in the Comparison areas (97%, n=346). The higher proportion of men in the SARC data suggests they are more likely to report where there is a SARC.

- Three-quarters across all areas were under the age of 35, and younger age groups were more common in the SARC areas. The age group in which the largest proportion was located was 16- to 25-year-olds.

- In contrast Black and minority ethnic victims/survivors were most evident in the Comparison areas, where they represented a third (34%, n=120) of complainants. This is partly explained by the demography of two Comparison areas, which are metropolitan boroughs, but at the same time the proportions at St Mary's and STAR were slightly below the Black and other minority ethnic populations in the area (see Appendix 1). Both St Mary's and REACH worked with a number of female asylum seekers (primarily from African countries) who had suffered sexual violence in their countries of origin.

- The majority of referrals to the SARCs came from the police (68%, n=2,161 across all three). All three SARCs also saw a proportion of self-referrals, with the highest percentages at REACH and St Mary's. REACH and STAR also receive a proportion of referrals from other sources, such as GPs, Victim Support, solicitors, Rape Crisis, Women's Aid and other health, psychiatric and support services.

- Both STAR and St Mary's had a high proportion of students – partly due to the adolescent service users who were still at school and, in the case of St Mary's, a large number of higher education institutions in its catchment area.

- A significant minority (5%, n=193) of the case-tracking sample had a disability, with the majority of these having mental health or learning disabilities. We suspect this may reflect vulnerabilities to sexual assault.

- Women known to be involved in prostitution also accounted for a small proportion, especially in the St Mary's and STAR areas (2%, n=31, and 3%, n=31 respectively). Given that the majority of these cases were police referrals, this suggests the inter-agency links in SARCs can make the service more accessible.

- The overwhelming majority of perpetrators were male (over 99%, n=3,510 across all sites), with the majority being single perpetrator assaults (91%, n=3,199).

- Strangers accounted for between a fifth and a third of perpetrators across all sites. Assaults by known men were more common amongst self-referrals (73%, n=488 compared with 58%, n=1,216 across all sites). These findings differ from those of Harris and Grace (1999), where the proportion of stranger assaults in reported rapes was said to have fallen from 30 per cent in 1985 to 12 per cent in 1996 (p5). The self-referral data also confirm that rapes by known men are still less likely to be reported (see also Myhill and Allen, 2002).

- Combining the categories of known men shows they are responsible for more than half of the assaults across all the sites.

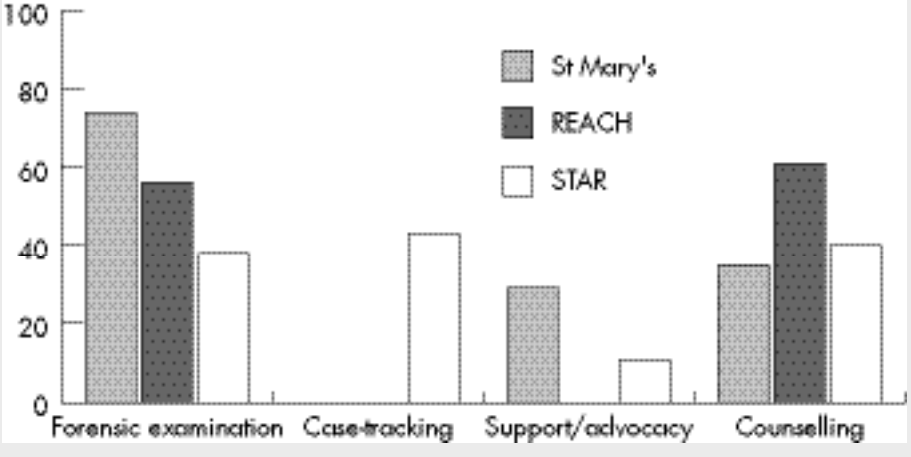
- One interesting difference within the self-referral group was the proportion of assaults that took place in another country (7%, n=70 of self-referrals, compared to less than 1%, n=7 of police referrals). These were a combination of asylum seekers and assaults that took place on holiday abroad.[18] In neither case was a legal case considered practical, but SARCs made it possible to access support and medical interventions where needed.

- The proportion of SARC service users reporting to police (74%, n=2,288 of 3,172) is made up of those who access it because they have already done so (94%, n=2,153) and a proportion who have done so either in the past or after having contact with the SARC (6%, n=135). All cases in the Comparison areas (n=355) had reported to the police.

18 In a small proportion of the latter cases, the assault was reported to the police in the country where it took place.

The case-tracking database also provides an overview of the take-up of services (see Figure 4.1) at the three SARCs.[19] The only common services are forensic medical examinations and counselling. The category support/advocacy covers the Support Worker functions at St Mary's[20] and the Initial Support Worker at STAR. Only STAR had a dedicated case-tracking service.

Figure 4.1: Take-up of SARC services



n=1,847 who had an examination, n=473 who used the Case Tracker, n=526 who accessed support/advocacy and n=1,335 who had counselling (multiple service use possible). Source: case-tracking database

SARCs undoubtedly increase access to services and support for a proportion – currently a small proportion given the high rate of non-reporting – of those who do not report rape, with each site having more than a quarter of their referrals from sources other than the police. This offers the possibility of preventative interventions such as medical examinations, pregnancy, HIV and STI tests, as well as offering access to support and counselling. There is far less evidence currently to suggest that SARCs increase reporting to the police, since according to the data from the services themselves[21] only a very small number of self-

19 As there is no consistent service provision, other than forensic examinations, available in the Comparison areas the analysis in Figure 4.1 only relates to take-up at the three SARCs

20 This calculation has been made on the same basis as others in Figure 4.1 – all referrals made during the evaluation period. However, a significant number (n=608 of 1,442, 42%) took place before the Support Worker was in post.

21 Record keeping in all SARCs is not as accurate as it might be, and thus the number might be inaccurate, but this is unlikely to be of such magnitude as to change the general point. It is also worth noting that the limited number of self-and other referrals that convert into an official report suggests that early fears that SARCs would exert pressure in this regard have not been founded.

referrals transfer into police reports. There is, however, room for more creative thinking here – such as asking service users whether basic details can be forwarded to the police as 'intelligence', which in turn might reveal local patterns of assaults. Such developments would, however, have to be located within policing strategies that increase the priority and resourcing of sexual assault investigations, including the possibility of using their own, and additional, data in a strategic and intelligence-led way.

5. Forensic and medical services

Whilst there has been relatively little research on forensic examinations as such, and certainly hardly any in the UK, wider studies of the process of reporting rape do shed light on what victims/survivors say makes the experience less traumatic (see Kelly, 2002a for an overview). These include: a female examiner;[22] privacy; a non-institutional setting; being talked through, and having some control over, the process. Problems in forensic practice which complainants (and professionals) highlight include: long waits; no choice about the sex of the examiner; the examiner appearing to disbelieve them; and routine, 'heavy-handed' examination (see, for example, Temkin, 1997, 1999; Victim Support, 1996). From an institutional point of view, lack of consistency in how evidence is collected and recorded and failure to link examinations to the facts of the case have also been noted as problematic areas (HMCPSI, 2002). In this chapter how far SARCs achieve the good practice noted above, and what the continued barriers in some areas appear to be are explored (Regan *et al.*, 2004).

The system for delivering forensic services is not consistent in either the three SARC or the three Comparison areas. Within the six areas there are two main types of service delivery: an 'integrated' model, whereby forensic examinations are conducted on SARC premises (St Mary's and REACH); and an 'outsourced' model (STAR and the three Comparison areas), where examinations are either conducted by a team of forensic examiners to which the police officers have immediate access (Thames Valley), or where the co-ordination is contracted out to a third party (STAR, Brent and Newham). This latter system represents the model where there is least 'control' by police or the SARC of the process. Examinations in outsourced models usually take place in a rape examination suite, which can be 'stand alone' or attached to a hospital or police station. Within the integrated model one critical difference is that at St Mary's a Crisis Worker supports and assists service users throughout the process, whereas at REACH the pre-examination information and consent issues and the post-examination debriefing have to be undertaken by the forensic examiner herself and/or the specialist police officer (SOLO).

> *I explain about the core services, I tell them which doctor it is that will come in eventually and speak to them, and then I explain what the forensic medical involves. I also mention that if they do elect to have a forensic medical, they can go in on their own or if they want some support from me – I never say from the police – or if*

22 Both women and men express this strong preference. They also prefer, though less vociferously, female police officers and female support workers/counsellors.

somebody's come with them and they want them in, that's fine. I also mention that they can have a shower after, and then I'll talk to them about counselling and STDs.

(St Mary's counsellor [who also acts as a Crisis Worker], F1, January 2001).

The Police Control Room will contact the doctor directly. The doctor will then make arrangements with the policewoman who is involved to bring the woman plus anybody who wants to be with her to this building or to the building in Sunderland depending on where the doctor is. We would then take an interview, then we'd take them through into the Medical Room next door and we would conduct the medical examination. Then the victim is offered a bath. They will be offered emergency contraception, they would be offered an appointment to see a counsellor. If they didn't want to make an appointment time then, they would be given details of how to contact the Centre to arrange one or we would ask permission to contact them in order to see if they wanted follow-up

(REACH, forensic doctor, F1, January 2002).

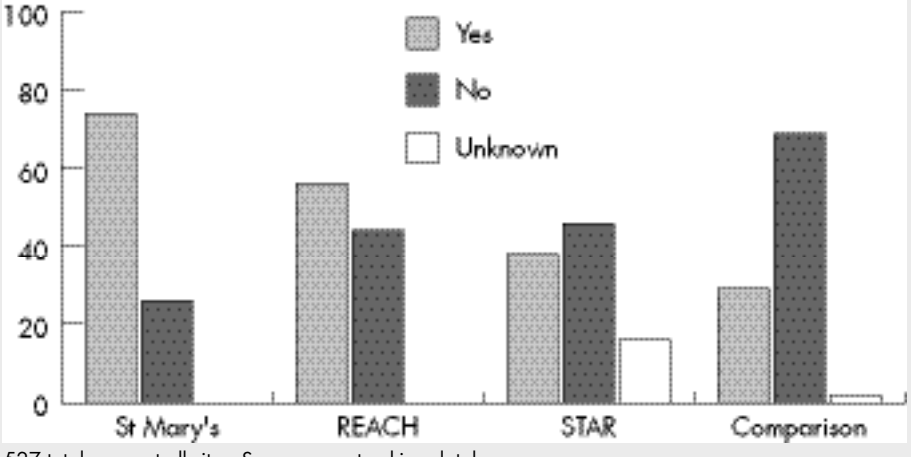
Number of examinations conducted

There were noteworthy variations across all sites in the proportion of total referrals who underwent a forensic examination (see Figure 5.2): St Mary's 74 per cent (n=1,072 of 1,442); REACH 56 per cent (n=356 of 638); STAR 38 per cent (n=419 of 1,092);[23] Comparison areas 29 per cent (n=104 of 355).

Not only did a higher proportion of cases result in examinations in the three SARC areas, but the two integrated sites also displayed significantly higher rates. The much higher percentage at St Mary's is partly accounted for by their higher police referral rate compared to the other two SARCs. Interestingly, a fifth of STAR police referral cases (n=218) did not have a medical, compared with minimal numbers at St Mary's and REACH (4%, n=59, 3%, n=21 respectively). Another major advantage of the integrated model is that forensic examinations can be undertaken and samples stored securely for both self-referrals and any police referrals who are uncertain about proceeding with the case (see Figure 5.3).

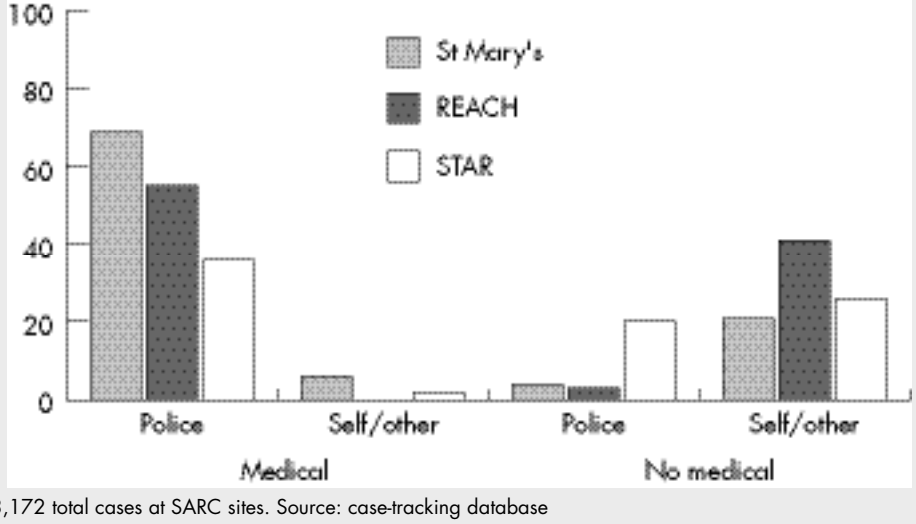
23 The percentage is probably higher, but data was weakest at STAR, with 176 cases (16%) where it was not known if an examination was performed. The absence of data is but one example of the limited communication where a third party is involved in service provision.

Figure 5.2: Number of forensic medical examinations performed



n=3,527 total cases at all sites. Source: case-tracking database

Figure 5.3: Number of forensic medical examinations performed by referral type



n=3,172 total cases at SARC sites. Source: case-tracking database

Questionnaire and interview respondents broadly reflected these patterns in terms of the proportions having forensic examinations. Of the 96 who did not have an examination,[24] 23 provided an explanation. The primary reason was the length of time between the assault and attending the SARC (n=11). Three noted an examination was not needed and a further two said they were too 'tired/confused'. Two respondents, however, (one each from St

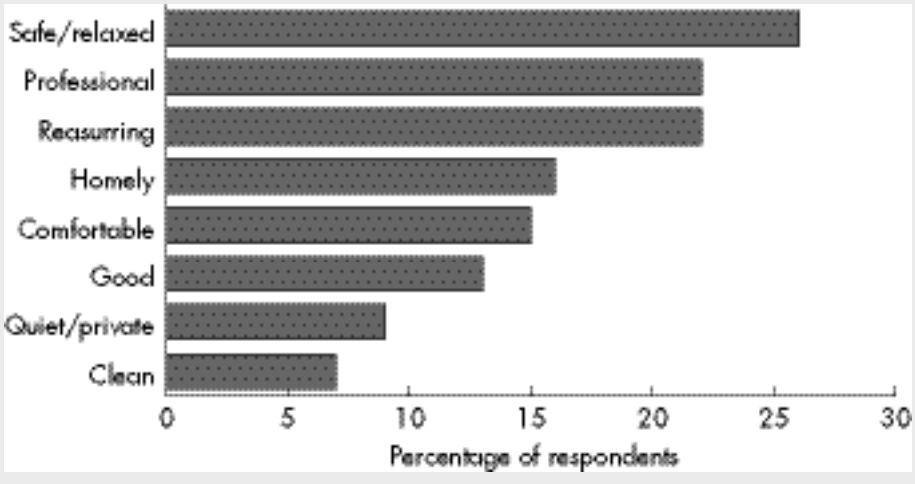
24 Twenty-three refused to have an examination, and for 70 (primarily from REACH and STAR) this service was 'not applicable' in their case, since the assault had happened some time previously and they were seeking support/counselling.

Mary's and REACH), cited 'pressure from the police' and four respondents (three from STAR and one from REACH) said they were not given the opportunity to have a medical. One STAR respondent chose not to go ahead because the forensic examiner was male, and one from the Comparison areas said they could not cope with anyone being near them.

The location/environment

The first impression for a victim/survivor is the location in which the examination is to take place. Respondents at St Mary's were asked to describe their initial impressions of the Centre and facilities in an open-ended, multiple response question. Their descriptions were overwhelmingly positive, with safety, reassurance and professionalism being the most frequently mentioned elements (see Figure 5.4).

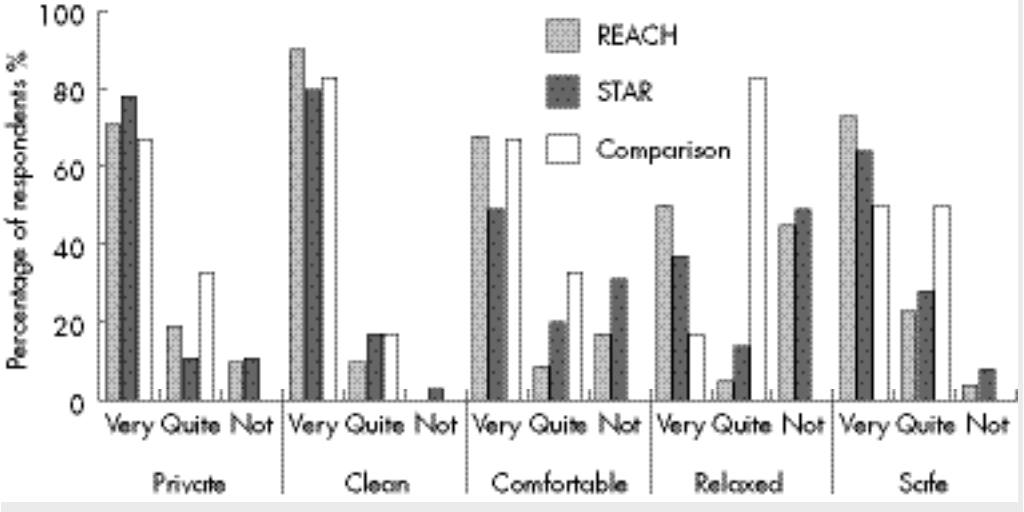
Figure 5.4: First impressions of St Mary's Centre and facilities



n=55 who answered the question, multiple responses possible. Source: service user questionnaire data

In all sites other than St Mary's there were several possible locations where an examination could take place. In order to assess perceptions of these locations respondents at these sites were asked to rate the examination facilities (see Figure 5.5). In most of these locations there were at least two rooms: one in which to talk, wait if necessary, and the examination room itself, which should meet high standards of cleanliness to avoid contamination of evidence.

Figure 5.5: Assessment of location in which medical conducted



n=63 to 64 who answered the questions about each variable (Privacy n=63; Cleanliness n=63; Comfort n=63; Relaxed n=63; Safety n=64). Source: service user questionnaire data.

The lack of consistency echoes national concerns about standards of forensic examination facilities expressed in the recent HMCPSI audit (2002), in which the designated specialist facilities available in SARCs, including St Mary's and REACH, were held up as examples of good practice. Data from this evaluation support this contention, showing that service users rated the facilities at the SARC with integrated services (REACH) slightly higher on all the measures except privacy, while their assessments of the facilities in the areas using an out-sourced model (STAR and Comparison areas) revealed greater variability. These views were echoed by police officers, with the vast majority of the 23 interviewed from the integrated SARC areas expressing strong approval of the facilities.[25]

I really do love it. It's a quiet, nice, relaxing place.

(St Mary's, police officer DC, F8, March 2003)

Yes, absolutely great. I couldn't fault it. There's nearly always all the equipment that should be there and, for us, all the kind of evidence bags and swabs and everything that a doctor would need for the examination.

(REACH, police officer SOLO, F8, May 2003)

> *They are modern airy places with a number of waiting rooms, rest rooms which are furnished with soft lighting and things like that, magazines, there's television, tea and coffee making facilities – everything that would encourage the victim to relax.*
>
> (REACH, police officer SOLO, F9, May 2003)

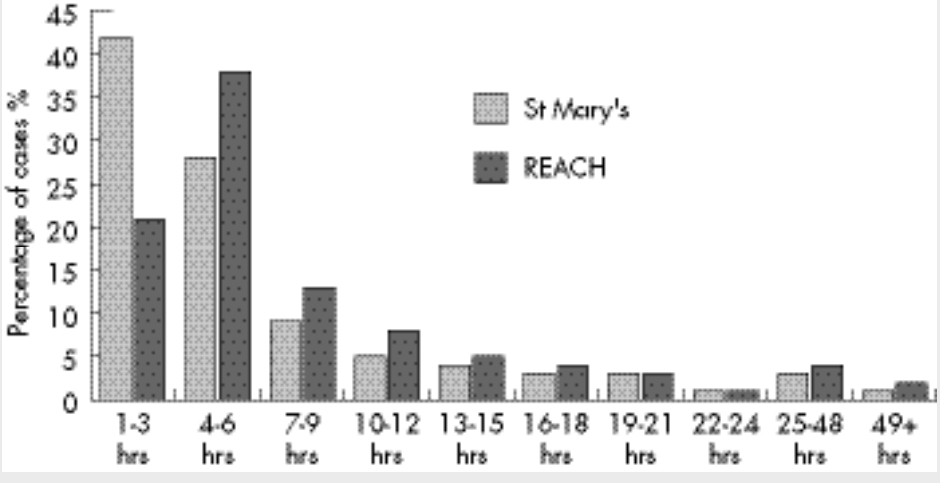
Speed of response

Delay between reporting and access to a forensic examiner has been an issue of major concern, which SARCs have attempted to address. Speed of response has been calculated from the time the assault was reported to the police to the time of attending the SARC, since this roughly correlates with the time of the examination, where both sets of dates and times were available. The data from STAR and the Comparison areas were especially poor in this respect, illustrating how integrated SARC provision provides greater ability to monitor these questions. Data is presented (Figure 5.6), therefore, for St Mary's and REACH only. Readers should bear in mind that there are some justified reasons for delays: the travelling time from police divisions can vary considerably; where a police officer telephones and there are already one or more cases booked in, the SARC may have to offer a delayed appointment by as much as four hours; and in a small number of cases the delay may be much longer where the victim/survivor has physical injuries that must be attended to first, or where they are so drunk/distressed that it would be unethical to conduct the examination immediately.

Just under half (42%, n=379) of examinations at St Mary's were conducted within three hours, rising to well over two-thirds (70%, n=630) within six hours. The average (mean) time lapse between the police report being made and forensic medical examination being conducted was 8.1 hours (median 4 hours), with three-quarters (75%) falling below the mean. Excluding cases examined 49 hours and over (n=12) after the police report causes the mean to fall to 6.7 hours (median remains 4 hours). At REACH the proportions were lower, with only a fifth (21%, n=62) conducted within three hours, rising to over half within six hours (59%, n=175). Here, the mean time lapse was noticeably higher at 16.9 hours (median 6 hours), with the majority (86%) falling below the mean. Excluding cases examined 49 hours and over (n=7) after the police report causes the mean to fall to 8.2 hours (median 5 hours). The forensic nurse pilot, which aimed to decrease waiting times during the day by providing greater availability, undoubtedly contributed to the better performance at St Mary's.

25 One officer in the REACH area did express concerns about the route from car park to the Centre located in a residential house at night, and one from Manchester felt the examination room at St Mary's was "too clinical".

Figure 5.6: Time from police report to forensic medical examination



n=1,201 where dates/times known (St Mary's n=906, REACH n=295). Source: case-tracking database

It's the office hours that have caused us problems, and the very early hours of the morning… the sort of five, six o'clock in the morning. So the benefits of having [the forensic nurse], are that – she's filled that gap in the rota, if you like.

(St Mary's, police liaison officer, M2, July 2002)

Unfortunately we only have a service for a medical examination between 6.00pm in the evening and 6.00am in the morning so if they report a rape at nine o'clock in the morning, they may be told, 'well, your medical examination is at 10.30 tonight'. Obviously it isn't ideal.

(REACH, police officer CID/SOLO, F10, May 2003)

Intervals between making a report to the police and undergoing a forensic examination are only available for questionnaire respondents from the STAR, REACH and Comparison areas. Of the 39 STAR respondents who underwent a forensic examination, all but one (97%, n=38) provided details of the time lapse, with the largest group (42%, n=16) having to wait in excess of four hours. A similar pattern was evident amongst REACH respondents, with over half waiting more than four hours (57%, n=12). Only three respondents (of the 7 who underwent a forensic examination) in the Comparison areas answered the question on how long they had to wait: two waited less than four hours, one more.

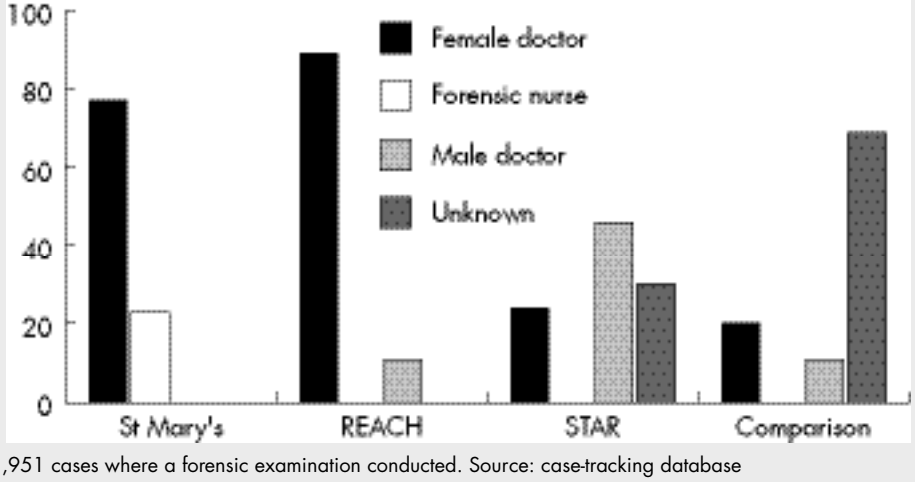
Whilst integrated SARCs can claim more consistent access to forensic examiners, where there are no provisions for weekday daytime cases, and the majority of examiners are

GPs,[26] significant delays can still occur. One route for resolving this has been a forensic nurse, while the practice at The Haven in Camberwell has been to recruit and train a pool of hospital doctors, who have more flexibility in their shifts.

Sex of the examiner

A major difference across the areas is the availability of female examiners. At St Mary's a female examiner is the default position, although a male can be found for anyone expressing this preference; at REACH the primary team consists of female examiners, but the case-tracking data reveal that all male victims/survivors were examined by a male doctor (11%, n=40); in the STAR and Comparison areas there is no guarantee, even when explicitly requested, that a female examiner will be available (for example, there are only three women on the rota in the STAR area). Figure 5.7 presents the sex of examiners for the cases where a forensic examination was undertaken. Male examiners conducted a significant proportion of examinations in the areas using outsourced models (STAR 46%, n=193; Comparison 11%, n=11), and the majority here were female complainants (STAR 93%, n=180; Comparison 100%, n=11).

Figure 5.7: Sex of forensic examiner



n=1,951 cases where a forensic examination conducted. Source: case-tracking database

26 The latter applies to many of the examiners at St Mary's and REACH.

Questionnaire data confirm the findings of other studies: that most victims/survivors (83%, n=90) have a strong preference for a female examiner, expressed either in statements about not wanting a man near/to touch them (44%, n=48), or a more positive sense that a woman would make them feel safer, or be more caring and sensitive (39%, n=42). Interviewees expanded on these responses.

> *It did make me feel better it were a woman, certainly. 'Cause I wouldn't have done it if it were a bloke… I would have just gone home and not had anything.*
>
> (St Mary's, service user, Interview 4, Detected, no proceedings)

> *They gave me the option of whether I wanted a female or a male doctor as well… [and that was important] 'cause it's not really very comfortable at the best of times having them kind of things done. I imagine it's worse at the best of times with a male than with a female, but at the worst of times, it's a lot better having a female!.*
>
> (STAR service user,Interview 15, Undetected)

> *I had a doctor, and that was a male doctor, so that freaked me out again… I was very, very frightened… I was so relieved afterwards that he, you know, he'd finished… I think I could have had a lady doctor.*
>
> (Comparison,Interview 4, Undetected)

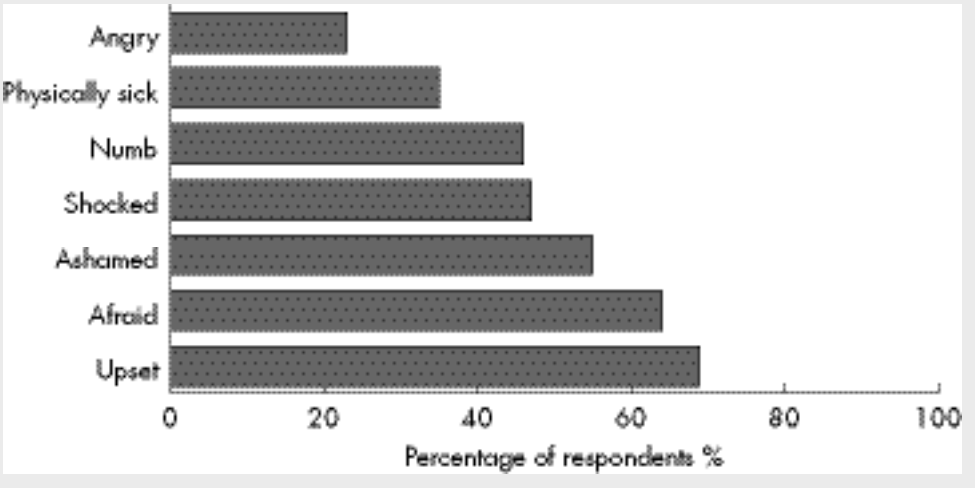
> [It was a male doctor] *who examined me… I felt really uncomfortable… That's just what was made available… I just felt shocked, and I just thought, 'Just get it over with.' I felt intimidated.*
>
> (REACH, service user, Interview 5, No crimed).

The views of complainants were confirmed in interviews with SARC staff, and police officers in the STAR area expressed unprompted concerns about the lack of female examiners. Most police officers in the Comparison areas asserted they could find a female examiner if one was requested, but this was not borne out by either the case-tracking data or the research participants from those areas. One interesting finding to emerge here is that at St Mary's, where female examiners are the norm, virtually all the men attending chose to be examined by them. The last quote above is from a male REACH service user, who also happens to be gay. These data confirm that good practice is to provide female examiners as the default position, for women and men reporting rape and sexual assault. Only the integrated SARCs provided, in the case of St Mary's, or were in a position to provide, in the case of REACH, this most basic requirement.

The practice of medical examiners

The data also reveal that the sex of the examiner is, in itself, not enough to guarantee good treatment. Questionnaire respondents and interviewees were asked a series of questions about the forensic examination, which reveal that how the examiner behaves makes a huge difference to them. Figure 5.8 reveals how questionnaire respondents were feeling just before the examination; their anxiety and distress underline what a daunting prospect such an examination is, requiring care, sensitivity and understanding from the examiner.

Figure 5.8: Feelings before the forensic medical examination



n=127 at all sites who answered the question. Source: service user questionnaire data

Questionnaire respondents assessed the examiner on a series of qualities. Whilst the numbers in the Comparison group are very small, their assessments were the least positive, and the two integrated SARCs scored highest. An overall assessment of the examiner was also requested, with levels of satisfaction reported as: St Mary's 79 per cent (n=49); REACH 68 per cent (n=15); STAR 31 per cent (n=11) and Comparison areas 50 per cent (n=3). Interviews were even more revealing, with clear appreciation of a calm and respectful style, being given information throughout and control over the process.

> *The medical was treated with the utmost respect. Everything explained to me. I didn't feel afraid. Initially I felt embarrassed, but then I realised, you know, why I was there. And it needed to be done… and because of the way the doctor handled me and explained I didn't find it traumatic.*
>
> (St Mary's, service user, Interview 10, Acquittal)

They were fine, they were really kind, everything was really nice… at no point was I made to feel that it was anything but his fault, that they believed everything I said, they had no doubts about what I was saying… I didn't feel judged, I felt as if they were there to look after me. And I felt very secure in that, I didn't have any worries.

(St Mary's service user,Interview 7, Unreported)

She was lovely, she was really, really nice. I'm not quite sure how long it lasted, it was quite a long time, it was about an hour, but she was very professional and considerate, throughout… But her approach made a big difference to me.

(REACH, service user Interview 9, Status unknown)

Negative experiences were linked to feeling disbelieved or failure to understand the care with which the procedures needed to be undertaken. Here, the practice of some examiners, both male and female, left much to be desired.

But when I got to St Mary's, it was the first point at which I encountered somebody that didn't seem to believe me, and that was the doctor that did the forensic examination… The doctor tried to sort of tell me that I'd maybe drank too much… As far as the examination, she was very respectful in terms of, you know, making sure I was covered up and explaining things… But obviously we'd just had this conversation five minutes before in which I felt she didn't believe me, and it's very hard being examined by someone that, you know, has just implied they didn't believe you… The thing that lasts… is whether you were believed or not.

(St Mary's service user, Interview 11, Undetected)

I was then examined by a male doctor who was very in my face, and couldn't understand why I am scooting backwards from him… He had been told what had happened, and what I had just been through, and this man was physically on top of me… He could have been a lot gentler over it. I know they're rushed, I know they're busy, and they're understaffed and overworked, but he knew the circumstances. And he didn't make any allowances for it whatsoever… It was his attitude towards it. It was almost a case of "So what?… You're all right".

(STAR, service user, Interview 13, Undetected)

I felt with it being a female, she would have been more sensitive to the way I felt. But she were rough, she were very rough. You know, like when they do the swabs, they were more or less shoved in rather than, you know, gently put in... She should have talked first and gone into detail [about] what they have to do, and been a lot more sensitive to the person.

(STAR, service user, Interview 11, Detected no proceedings)

Having the process explained and taken step by step emerged as a very important element in making the process a less traumatic one. As with other measures the two integrated SARCs were more consistent in this respect, including making victims/survivors really feel that they could stop at any point, and that they were in control of the process (65%, n=41 at St Mary's; 38%, n=8 REACH; 27%, n=10 STAR and only one respondent from the Comparison areas).

The doctor was really nice. And then she also asked me was it all right if she did this, she told me everything before she was going to do it, every single thing, even down to "This swab now, I'm going to take a swab of the bruising that's, you know, inside," etc. Yeah, before she did anything she explained to me and shown me what was going to happen.

(St Mary's, service user, Interview 10, Acquittal)

She was nice, she cared and she explained everything and she took her time, and she said that if I didn't feel comfortable she'd stop as well.

(St Mary's, service user Interview 3, Undetected)

One of the interviewees and her friend, who she was visiting, were raped in the STAR area, and the case handled poorly by local police. Our interviewee was not offered a forensic examination by police there, and only had one several days later at REACH after approaching the police for a second time, this time in her own area of residence. Her comparison of the two experiences and practices is particularly revealing.

The medical examinations were so different. Basically before my examination took place the doctor went through a kind of statement with me, saying this is what's going to happen. She explained exactly what was going to happen, how she would try to make me as comfortable as possible, the areas she was going to need samples from, that at any point I didn't want to go forward her examination would stop… My friend she had the examination, as I say, by a GP, in the police station, and the doctor talked to the police officer in the background, didn't talk to her, she was never

read her rights beforehand… there were so many samples that weren't actually taken from her. They didn't take blood samples, they didn't take hair samples… the drug that they suspect we were given, one of the last places you find it is in the hair follicle… I rang up and complained and said, "Why is there such difference between the medical examinations? I know that you need these samples"… they took the samples from her the next day.

(REACH, service user, Interview 9, Undetected)

On all the measures of choice and control[27] St Mary's and REACH scored highest, with good practice appearing to be most embedded at St Mary's. In all areas, however, there were examples of practice not attaining the high and consistent standards that complainants have the right to expect.

Discussion and reflections

On all the evaluation questions with respect to forensic practice, with the exception of quality and consistency of evidence, where data were not forthcoming across all sites (see Chapter 2), the two integrated SARCs scored highest: a greater proportion of their service users had forensic examinations; the vast majority were examined by women; and the examiners were more likely to conduct the examination with care and sensitivity, including offering as much control as possible to the victim/survivor. This may be due partly to differences in training, as well as the greater potential for developing expertise and monitoring practice that being part of an organisation affords, particularly one dedicated specifically to supporting victims of rape and sexual assault.

Interviewed police officers working in the St Mary's and REACH areas (n=23) were all positive about the forensic service provided by integrated SARCs, whereas a proportion of their colleagues in the STAR and two Comparison areas where third parties were involved (n=14 of 20) were decidedly less sanguine (in the STAR area these misgivings were echoed by SARC staff and local forensic examiners). Issues highlighted included both training standards and accessibility.

27 Respondents were asked a series of questions about the forensic examination, including: whether the process had been explained to them, and at what points; whether they felt in control during the examination; whether they were able to tell the forensic examiner how they were feeling; and how they would rate the forensic examiner's response to them in terms of respect, belief, support, help, sympathy and judgement.

Now we go through [contractor]*, and that can be a lottery as to who you get – you can get people* [who are] *very, very good and very experienced; you can get people* [who are] *very, very poor and inexperienced.*

(STAR, police officer CID, M5, April 2003)

I think it's much worse. I don't think they always get a doctor who's been trained properly. Things sometimes get put off till the next morning. The service isn't the same at all. There was far more co-operation between the police officers and the doctors before. Now, because it goes through a third party, there isn't the same close association. I mean the police had problems before getting doctors to do examinations, but I think it's probably worse now.

(STAR, forensic examiner, F3, April 2003)

Police officers at the third Comparison site, where they organise access to examinations, were generally positive, but concerns were expressed by a third (n=6 of 19) about delays, especially during daytime hours.

It's not actually the doctors being bad about not coming out, it's because they're maybe in the middle of a surgery and they'll come out when the surgery's finished, but three or four hours is totally unacceptable expecting a victim to wait.

(Comparison 3, police officer DC, F13, February 2003)

I would say the actual access to doctors – I would almost use the word 'appalling'. And that wouldn't be too strong a word to use. There's been an incident over the weekend, we've had a victim, and we couldn't get her to see a doctor for about two days.

(Comparison 2, police officer DS, M1, February 2003)

Most police officers expressed a preference for examination suites in locations away from police stations, although some concerns were raised about safety and access, especially to facilities based in remote or quiet locations. The STAR manager described the location of one such examination suite.

At night it is frightening because the surroundings are so nice but there are no street lamps. So it is really dark at night. It is quite scary because it is so remote.

(STAR, manager, F1, April 2003)

Overall the integrated SARCs were the most consistent in meeting a standard for prompt and consistent responses, although only St Mary's had someone (the Crisis Worker) separate from

the legal process who provides support, explanations and debriefing before, during and after examination.[28] The outsourced model where third parties co-ordinate provision of forensic examiners performed least well, and is also the one where communication, dialogue and monitoring were difficult to maintain. Daytime examinations were an issue at all sites, resolved at St Mary's through the forensic nurse pilot (Regan *et al.*, 2004).

Training and developing good practice is vital to ensure that consistent, professional and dignified responses in forensic examinations become the norm. Practitioners need to be aware of the meanings sexual assault will have for victims, and that they are likely to be feeling dirty, ashamed, vulnerable and extremely sensitive to any implication that they are not telling the truth. It is these realities that make the environment in which examinations take place so important. A private, dedicated space, which combines clinical needs for cleanliness in the examination room with a separate calming and relaxing location to undertake counselling and support, are minimum requirements, and have seldom been achieved in the semi-detached examination suites. In addition, good practice embeds across a group of practitioners when they are connected to an institution, in this case SARCs, which has an interest in supporting and developing their skill and capacity. Female examiners should be the default position, since it is clear that the vast majority of women and men who have been sexually assaulted express a strong preference for this, and a small percentage will refuse an examination if the individual undertaking it is male.

28 In North American models this role is played by a victim advocate, often through links to the equivalent of Rape Crisis Centres.

6. Support, advocacy and counselling

Obviously all SARC services are intended to be supportive, but some are designed specifically to provide this: the Crisis Workers at St Mary's, the Initial Support Worker at STAR and the helplines. Whilst proactive contact and advocacy have not been core elements of provision to date, both the Case Tracker at STAR and the new role of Support Worker at St Mary's fall under this heading. All of the SARCs provide counselling and some form of helpline. This provision distinguishes SARCs from areas where no such service exists, making contrasts with the Comparison areas complex, and in some senses unfair. What can be said, however, is that in these areas far greater responsibility falls on specialist police officers, many of whom have 'victim care' as a core component in their job descriptions. Whilst having a sensitive and caring approach to victims of rape should be expected from all professionals working in the field, there is a strong case for arguing that 'victim support' is not the role of the police, whose limited resources are best devoted to services only they can deliver – investigation and evidence gathering.

In the chapters that follow the range of models of initial support, proactive contact and advocacy, and counselling currently available at St Mary's, REACH and STAR, including the key aims of each role, type of provision and service user assessments are outlined.

Initial support

The two variants here are the Crisis Workers at St Mary's and the Initial Support Workers (ISW) at STAR. The former offer immediate crisis intervention and advocacy at the initial point of attendance of the SARC and during the forensic examination, while the latter offer support at a slightly later point to help service users address personal and practical issues in the immediate aftermath of rape.

Crisis workers: St Mary's

Key aims of the role:

- To provide crisis support to service user on initial attendance of SARC.
- To support service user before, during and immediately after forensic examination.

- To provide support, advocacy and information about the reporting, examination and SARC processes.
- To liaise with forensic examiner and any attending police officer on service user's behalf.

Type of provision:

- Automatic for all service users attending SARC for a forensic examination.
- Female workers only.
- One-off contact.

A Crisis Worker is available to meet and accompany all victims/survivors[29] attending St Mary's from the point of arrival, and support them both through the examination and post-examination. They would not normally have any further contact, making this a time-limited role, although staff members are part of the Crisis Worker rota and may meet service users in another role.[30]

> *I see my role as an advocate, the client's advocate, and I explain… that I'm not part of the legal system, I'm not part of the investigative process, I'm not part of getting medical evidence. What I'm there to do is give information so that a client can make an informed choice. And, again, I think that's a word which is used quite often – "We'll give you a choice. But you don't really feel that you have one. That's what I see my role as… to give them choice right from the word go. One of the first things I always say is that nothing's going to happen here that they don't give their informed consent to, and they can stop things at any point.*
>
> (St Mary's, counsellor, F2, January 2001)

Interestingly, a higher proportion of service users, both police and self-referrals, choose to undergo an examination at St Mary's than any of the other sites, raising the possibility that skilled Crisis Workers are a factor in this.

Almost all St Mary's respondents understood the role of the Crisis Worker (89%, n=54). Of the seven (12%) respondents who did not understand, three were confused generally at the time, two said they had not been given sufficient information, with two providing no explanation. As with the forensic examiner, it made a difference for most (82%, n=48) that the Crisis Worker was female, and here the predominant reason, for those who gave one

29 On very rare occasions, due to sickness and holidays, there may be no Crisis Worker available.

30 St Mary's employs a pool of Crisis Workers who work on a sessional basis. Some are also counsellors, but they would not perform both roles with the same individual service user.

(64%, n=28 of 44), was feeling more comfortable or at ease (this includes the one male respondent who answered this question).

I felt safe.

(St Mary's, Q1, 1059)

It felt easier to talk to a female.

(St Mary's, Q1, 1004)

I felt comfortable and not exposed any further.

(St Mary's, Q1, 1035)

After being raped by a man the last person you want to talk to is another man. Women understand better.

(St Mary's, Q1, 1011)

I couldn't have told anything to a man as it was a man who had attacked me. I was scared.

(St Mary's, Q1, 1031)

Extremely high satisfaction rates with the Crisis Worker were evident among questionnaire respondents, with virtually all (93%, n=59) stating they were either 'satisfied' or 'very satisfied'. These are the highest scores for any of the SARC services, and interviewees' comments further extend understanding of the critical role of Crisis Workers.

They were fantastic with me. They told me not to blame myself. They were great.

(St Mary's, Q1, 1010)

I'd just like to say that the Crisis Workers at St Mary's was lovely, I was very scared and they made me feel so much better, they was very helpful and supportive to me and my parents because they was very upset too. Thank you for being so helpful.

(St Mary's Q1, 1020)

The Crisis Worker I had was excellent. She made the whole process bearable.

(St Mary's Q1, 1049)

It's as though they know exactly how to handle you, and they know exactly what to say. Because the care that you receive, the kindness, the tenderness, the gentleness

of the way they manage you... Everything, every step is explained... There's no timescale. It's in your own time, and you just kind of think, 'Right,' and you can feel yourself physically relaxing, and then becoming at ease. And you're safe, you're secure. Because the quietness and the way they speak to you, they have the utmost respect for you. You're feeling the lowest form of life that could ever be walking the earth, and they're treating you as something special! You know, they make you feel a special person. And then you start realising – I didn't do anything. But while they're asking you questions you're thinking 'I didn't do anything wrong'. The penny starts dropping. Well it did with me. The penny started dropping: I'd done nothing wrong .

(St Mary's, service user, Interview 10, Acquittal)

Service users clearly appreciated having someone who was 'there for them', whose lack of involvement with evidence gathering meant they had more freedom to respond to each individual's needs and concerns. Kindness and respect were recurrent themes in the interviews, as was being given messages that they were not to blame. The Crisis Worker role is one way SARCs can attempt to ensure that victims/survivors are treated with dignity, can make informed decisions, and have a supportive space in which to prepare for a demanding and potentially difficult experience.

Initial Support Workers: STAR

Key aims of the role:

- To conduct six face to face sessions, usually in the service user's home.
- To provide service users and their families with support, advice and information to help deal with the practical, social and emotional impact of the assault.
- To liaise with other agencies to obtain information on the service user's behalf.
- To maintain regular contact throughout the six-week period and consult with STAR to review the progress of each case, particularly where counselling or referral to other agencies may be necessary.

Type of provision:

- Determined by service user agreement and availability.
- Female and male workers according to service user's preference.
- Time-limited contact.

The ISW is also a time-limited role, although more extended than that of the Crisis Worker, with service users reporting recent rape entitled to six one-hour face to face sessions. These are usually weekly and are most often conducted in the service user's home, unless personal circumstances or proximity of the perpetrator mean this is not a viable option. Referrals are made from the STAR office to their trained local volunteers, who aim to make contact with service users within 48 hours of the referral. The dispersed nature of STAR's support services requires mechanisms for feedback from ISWs when they are supporting individuals, and in-service training provides a means for both updating knowledge and maintaining connections with the organisation.

The emphasis of the support offered is that it be flexible and adapted to the concerns of individuals. It might be limited to having a safe space to talk, or extend into practical issues and even elements of advocacy. The timing is linked to an understanding of rape through the concept of the Rape Trauma Syndrome (Burgess and Holmstrom, 1974), which posits a relatively short crisis phase, followed by reorganisation and adaptation. An ISW, therefore, assists the transition from crisis to reorganisation.

> *I'd basically visit them in their own home and listen to them a lot, explain that they could talk about anything, and it's confidential, set the ground rules, that kind of thing. And then help them with any of their main problems, like for instance one lady I went with her to the GU Clinic to be examined and blood tests taken for diseases, related to the rape. I've helped one lady to move house, not physically, been in touch with the housing association that she lived with because it was her next-door neighbour. Suggest a lot of things to them that they might try, to help them cope.*
>
> (STAR, Initial Support Worker, F10, December 2001)

According to STAR's data only eleven per cent (n=115) of their service users had chosen (this is an 'opt-in' service) to see an ISW. Whilst a proportion would not be eligible since they were seeking counselling with respect to historic assaults, this seems a rather low take-up.[31] It is possible that this reflects poor record keeping, since over a third of STAR (38%) respondents completing questionnaire one had wanted to see an ISW, with almost all (89%, n=31) having contact. Only half of this group had been given a choice about the sex of their ISW (four said they had a choice with respect to sexuality and three with respect to ethnicity); choice was appreciated by virtually all of those provided with it. Questionnaire respondents who had not used the ISW service were asked why not. Of those providing an answer (n=42), the most common reason was not being aware of the service (36%, n=15), a further third (33%, n=14) said they did not need it, and smaller numbers said they just wanted a counsellor, wanted to forget or preferred to talk by phone.

31 It should also be noted that during the evaluation period STAR did experience problems recruiting ISWs, and so may not have been able to offer the service across the whole county consistently.

The average number of sessions was five (mean 5.06, median 6), but this ranged between one and ten, the latter illustrating that there is some flexibility. The average waiting time for an actual meeting was eight days (mean 8.6, median 7), although seven respondents waited two weeks. However, all but one found it easy to set up an appointment.

Most of those seeing an ISW valued the service: almost two-thirds (59%, n=17) commented that it was 'friendly/supportive'; a third (35%, n=10) found it 'sympathetic/understanding'; and just under a third (31%, n=9) said it was 'helpful'. A minority (n=8) of those who had seen an ISW made negative comments, almost all of which referred to either the manner of the volunteer (disinterested, unsupportive, judgemental) or the fact that they were ill-informed. A complaint from half of those who had found the service useful (52%, n=11) was that six sessions were not enough; unsurprisingly the most common suggestion for improving the service was to make access open-ended. Five STAR service user interviewees had seen an ISW, four of whom were positive about the responses they had received.

> *I used to have a woman coming to the house, I think she was a volunteer. She was great... 'cause I mean she got in touch with everybody, and they all gave me like letters, you know, to get me moved, 'cause it happened in the home. But unfortunately I haven't been moved yet, no.*
>
> (STAR, service user, Interview 4, Undetected)

> *I were nervous and worried about it, but once she come, and started talking about stuff, she just made me feel relaxed, and I were quite comfortable talking to her. [She was] really nice. We didn't actually talk about the whole incident, but we talked about other stuff, and she just told me not to blame myself, and give me advice on what other stuff I can do, to pull through it all... I just told her that I wanted to go to college and do other things, like self-defence classes.*
>
> (STAR, service user, Interview 7, Status unknown)

> *He dearly is a credit to STAR, and if everybody's like he is, you know, they've been wonderful for me... I needed my phone changing quick, my number. Do you know, bless him, he come out, he said, "Right, give me your phone bill", and I give him my phone bill, and he rung up, and they said there'd be a charge and he told them the circumstances, next minute he says, "Your number will be changed within 24 hours, love, you'll be ex-directory, nobody will get it, and there's no fee to pay." And he did it like that for me.*
>
> (STAR, service user Interview 3, Undetected)

Whilst using volunteers is a cost-effective strategy in that their time is not being remunerated, and in the case of STAR enables localised access, there are inherent difficulties in ensuring the reliability and quality of services. This is accentuated by the fact that volunteers do not work out of STAR premises, making supervision more difficult.

Advocacy and proactive contact

There are two elements of SARC services that are proactive: the case-tracker service at STAR and the Support Worker at St Mary's. The latter was subject to detailed evaluation as part of the CRP Violence Against Women Initiative, and thus more information is available on this.

Case Tracker: STAR

Key aims of the role:

- To liaise with police and other criminal justice agencies to obtain up-to-date information on case progress.
- To relay progress information to service users by letter and/or telephone, including details of hearing dates and offender bail conditions.
- To collate details on STAR database.

Type of provision:

- Determined by service user agreement and case status (only reported, crimed cases where an offender identified).
- Female worker.
- Ongoing contact according to progress and outcome of case.

The only SARC with a dedicated Case Tracker is STAR, who describes her role below. At the most basic it involves being proactive in the gathering of up-to-date information on case progress by maintaining close liaison with investigating police officers and key criminal justice agencies, such as the CPS and courts, but a key aspect is relaying these details to service users to ensure they are kept closely informed. The service is limited to crimed cases where an offender has been identified, and is provided with the service user's consent. Contact with service users involves providing regular updates, especially with respect to any decisions that may affect their personal safety, such as bail conditions.

> *My role at the STAR project is tracking cases through the courts and informing our clients of what is happening…* [Information is gained] *through the police computer systems and liaison with courts. Obviously they're not always up to date on that day on the police computer system, so I ring the courts. I've got quite good relationships with personnel at the courts, the listings officer, sometimes the court clerks themselves. I persevere with it. Very, very occasionally* [I contact the CPS] *if there are any queries. And obviously I also keep the police officers up-to-date with what's happening because they don't always know.*
>
> (STAR Case Tracker, F1, December 2001)

The rationale underpinning the service is the repeated complaint from victims/survivors that they are not routinely kept informed (see, for example, Victim Support, 1996), despite commitments in the Victims Charter (Home Office, 1990).[32] A single agency taking responsibility for regular contact is one element in ensuring that disengagement from the CJS, a sense of being 'dropped' after the initial flurry following a report, is not the outcome of system failures. A STAR counsellor outlines how she thinks this makes a difference.

> *I think sometimes the police don't keep them informed as well as they would like to be informed. They say "We will ring you" and then maybe three weeks will go by and they haven't rung them. That's probably because they have nothing to tell them, but they don't know that… Now some of the police are absolutely brilliant apparently, they will ring regularly and just say, "We're just updating you, we have no further information but I'm checking out are you OK?" But there are other ones who, unless they actually have definite information, they don't make that contact, and I think that makes an awful lot of difference.*
>
> (STAR, counsellor, F3, April 2003)

This was confirmed by the questionnaire respondents, a substantial proportion of whom, by the second questionnaire (64%, n=50 of 78) thought they had not been kept well-informed about the case. More than half of interviewees who had reported to the police (52%, n=23 of 44) across all sites felt let down by the police, who had given assurances that they would keep in touch and make sure they knew about developments.

> *OK, yes, I get support here* [St Mary's]*, I'm not knocking that at all, but I get nothing from the police, at all. Nothing. It's as if I'm just a statistic, and they've done their bit, and why bother to let them know what's going on. And I would just like to get a little*

32 See also the leaflet '*Giving a witness statement to the police – what happens next?*' (Home Office Communication Directorate, 2003, http://www.cjsonline.gov.uk/library/pdf/giving_%20statement_police.pdf).

bit of feedback. Last time I heard was October. I mean, it's five months ago. Five months and I know nothing. I don't know whether they've got anywhere near, I don't even know they're bothering any more. Are they bothering?

(St Mary's, service user Interview 7, Undetected)

There was a degree of support to begin with, but then I think it sort of waned, I remember phoning up a few times about a couple of things, I was told that the liaison officer was out on another case at the moment and there was a heavy workload at the moment and they'd try and get her to call me back, but I'd got the impression – well, in fact, I think somebody said this to me, that they're short-staffed, and that the liaison officer [has] *to go out on new cases. Basically I felt that they go out on new cases, they get their statements because they want to get their convictions, and then there's no support or back-up service, there's nobody, there's not the resources, the people, to be able to provide the back-up for the people, you know, with cases that are ongoing… I needed somebody to talk to. So when I phoned up to speak to people they were never there. That's what I needed – I needed to be able to talk to people, to check that what I was doing was the right thing, to have reassurance, just to talk things over really… but as the victim afterwards I just felt like I was sort of dropped, really.*

(Comparison, Interview 6, Detected/Victim withdrawal)

Over half of the police officers interviewed (52%, n=32) recognised the importance of keeping victims informed, although there was an interesting variation across the four areas, with awareness far greater in the SARC areas (REACH 91%, STAR 69%, St Mary's 58%, Comparison areas 26%).

They need updating with the information. They need to know where the defendant is, whether he is on remand, whether he is on conditional bail. They need to be kept fully abreast of any developments of any changes of circumstances or changes in the case. They need to be kept aware of any court appearances that the defendant may be making or any bail variations that the defendant wants to change.

(STAR, police officer CID, F10, April 2003)

One police officer in the Comparison areas made insightful observations about the possible links between lack of contact and victim withdrawal (which were also hinted at in the quote above from the complainant in the Comparison area).

> *There is still very definitely the feeling that the police won't believe them, that the police aren't interested. And that is where the role of* [police] *chaperone is so important. Because if we don't have the chaperone making regular contact with the victim, the victim feels neglected, and then wants to withdraw. And once they've made a decision to withdraw, it's very difficult then to talk them back on-board. Because of course they think "Oh they're just doing this because they don't want to land themselves in trouble because I've withdrawn".*
>
> (Comparison 1, police officer DS, M3, March 2003)

Whilst police have responsibility, under the Victim's Charter (Home Office, 1990), for keeping victims/witnesses up-to-date, and the specialist officers interviewed across the research sites viewed this as their responsibility, a number noted that they had neither the time, nor always the information, to fulfil this role adequately. They also highlight that one of the needs is simply for contact, which arguably, despite current policy, is something agencies other than the police might be better placed to provide.

> *I think a lot of them would say well we'd maybe like a phone call every other day, because they want to know what is happening all of the time, and that's very, very hard because we simply don't have that time to spend. And there's often nothing to actually tell them, because if you're sending stuff off to the lab, it can be months before it comes back, on a non-urgent case. And I think what they need* [is] *someone there for them to talk to, but unfortunately we're not really best placed to carry out that role. I think probably most victims would say that they're not kept up-to-date enough.*
>
> (Comparison 3, police officer DS, F18, September 2002)

Just under half (43%, n=473) of service users at STAR accessed the case-tracking service, but this was over half of cases where a report had been made to the police (57%, n=472 of 835) and almost all cases where an offender was identified (90%, n=464 of 518). STAR questionnaire respondents reported less take-up (accounted for by those who had made no official report in the sample), and this declined over the year of contact (see Table 6.2) with the research team - reflecting the small proportion of cases overall that are proceeded with, particularly to the point of trial. Almost half of those who gave a reason for not using the service said this was either due to not reporting to the police or the case being dropped at an early point (47%, n=23). However, almost a third (31%, n=15) reported not knowing about the service (only two of these cases were no crimed, making the respondent ineligible).

Table 6.2: Take-up of case-tracking service at STAR by questionnaire respondents during evaluation

Stage used	Total respondents	Number using Case Tracker	%
Questionnaire 1	91	28	31%
Questionnaire 2	59	15	25%
Questionnaire 3	36	4	11%

Almost three-quarters (n=14) of those who discussed use of the Case Tracker in the first questionnaire praised the accurate information they received, and three respondents liked the fact that it was 'outside the police service'. Six negative comments were made: three concerned perceived delays; one would have preferred face to face contact; one reported that it was 'a bit of a shock getting the letter'; and one was upset about the case outcome rather than the service itself. Almost all who had used the service at later points in the process reported being either 'very satisfied' or 'satisfied', although about a fifth wanted more contact, and speedier communication. These variations were also reflected in interviews, where it was also notable that several appreciated the proactive nature of contact.

> *It's nice to know that you can be told what's going on. You know, even though my mum and dad did go to the Magistrates' Court and told me what had happened. You get… a better in-depth view of what has gone off through the Case Tracker, and at least you know that he's not going to be out stalking you or owt like that.*
>
> (STAR service user, Interview 6, Guilty plea)

> *I've been in touch with them for the case-tracking and I used to ring them rather than the police to find out kind of what was happening and stuff, and they were really good with that… they were always sending letters saying like he'd appeared in court and the police never did that… I thought it was really useful, because it was basically the only source of information that I was getting, and I wasn't having to ring up people to get it. They were always in contact with me. Like it was always the same lady that rang me, she'd either ring or send letters, or both I think most of the time, even like when there wasn't much information, just like little things, just to say he was going to be in court – I thought it was really good.*
>
> (STAR service user, Interview 14, Conviction).

Dissatisfaction with the service, somewhat inevitably, became intertwined with discontent about the legal process. The STAR co-ordinator noted it was the aspect of their service "that seems to attract the most thanks from clients and police officers alike" (STAR, project co-ordinator, F1,

December 2001), and that it acted as a form of networking and strengthened inter-agency links. All of the police officers interviewed in West Yorkshire echoed these sentiments, and revealed how often they are unaware of recent developments once cases are transferred to the CPS.

> *I find out things from the STAR project about the conduct of the case that I haven't been told by the CPS. They seem to keep me informed better than the CPS do.*
>
> (STAR, police officer CID, M8, April 2003)

The STAR service users' experience and assessments contrasted sharply with participants from areas where there was no Case Tracker, where they were reliant on the police for information. Although a small number at STAR noted possible improvements, the data suggest that provision of a dedicated Case Tracker can contribute to ameliorating this aspect of the process for complainants.

Support Worker: St Mary's

Key aims of the role:

- To support service users during statement-taking.
- To conduct proactive follow-up contact with all service users attending St Mary's for a forensic examination, both police and self-referrals.
- To provide support, advice, advocacy and information.
- To promote access to St Mary's and other community-based support services.

Type of provision:

- Support during statement taking determined by service user agreement and availability
- Proactive follow-up automatic, unless service user has requested no further contact from SARC.
- Female worker.
- Support during statement taking, one-off; proactive follow-up ongoing according to need.

This post was funded under the CRP Violence Against Women Initiative, to implement two interventions – support in statement-taking and proactive re-contacting – as well as to explore the process of attrition (Kelly *et al.*, 2004). Increasing police statement taking at St Mary's with a Support Worker present was piloted in the hope that it might address the perceptions

of disbelief, disrespect and miscommunication that some victims/survivors report. In turn, it was hoped that improved evidence gathering would occur, since statements would be taken in a supportive and conducive context. The second intervention involved the establishment, for the first time in UK service provision for rape survivors,[33] of proactive follow-up at regular intervals after attending the SARC, especially for those cases proceeding through to court. Both interventions were intended to decrease early withdrawals.

Up to this point a culture of client-led service provision has predominated in specialist violence against women services, reflecting a particular understanding of client control of contact as a form of self-determination. This philosophy has underpinned practice at St Mary's since its inception. However, lessons learned by some services responding to domestic violence (see Burton *et al*., 1998; Kelly, 1999) suggest that a proactive approach had much to recommend it. Applied to rape this intervention sought to ensure victims/survivors felt supported in continuing with a legal case, could access protection measures if necessary, had an opportunity to discuss withdrawal before making a final decision, at the same time as facilitating access to St Mary's and other community-based support services and resources.

This chapter examines the statement-taking and proactive follow-up interventions, what they revealed about service user needs, and whether they had the intended impact on withdrawals. In addition to the data outlined earlier, log forms completed by the Support Worker, and statement-taking by police officers are included in the analysis.

Statement taking

Between 24 September 2001 and 31 December 2002 the Support Worker attended 30 statements. During this period 623 cases were reported to the police, and in 356 (57%) of these, it is known that statements were taken: thus the offer to attend statements was taken up by less than one in ten (8%) of St Mary's service users. Take-up of this intervention was lower than anticipated for a variety of reasons: those aged 16 and under were excluded from the outset, given the different procedural rules and likelihood of a videoed statement; the availability of the Support Worker was limited to 9am-5pm, Monday-Friday, with no cover for holidays and sickness. The case-tracking database allows the researchers to exclude cases where any of these factors apply, as well as those where a statement had been taken prior to attendance at St Mary's, or before the Support Worker was able to contact the service user. This reduces the potential number to 207,[34] and in 114 of these a

33 Aspects of case-tracking can be viewed as proactive, but it involves the provision of information rather than support, and also seems to require an 'opt-in', rather than being routine practice.

34 Excluding cases: involving those aged 16 and under (n=135); reported over the weekend (n=208); where statement was taken on a Bank Holiday or during worker holidays (n=50); where statement videoed (n=12); where statement taken before attending (n=11).

statement was taken, although the researchers cannot be sure that all 207 were offered the service; calculated in this way the take-up rate is more than a quarter (26%).

The service user questionnaires further suggest that the police were not routinely offering this option: less than half of those who would have been eligible (n=9 of 23) said the police had told them about the scheme.[35] That said, under a third of those answering these questions thought this was a service they might use (31%, n=15). Our attempts to gather more feedback on the intervention from service users were not that successful, with only five completing a short log form. All of these statements were taken at St Mary's, and all five rated the police officers and the Support Worker as respectful and believing and none thought they had been asked inappropriate questions. They also concurred that her support had made them feel safer and more relaxed. Comparing this group with questionnaire respondents who made their statements at a police station (n=17)[36] there was much less consensus: five experienced police officers as disbelieving, unsupportive and unsympathetic; four viewed them as unhelpful and judgemental; and three felt disrespected. These data, though based on very small numbers, suggest that the presence of the Support Worker may influence both how police officers respond to victims and how victims experience the statement-taking. There was further support for the former in interviews with two police officers, who honestly admitted that a sense of being "watched" limited the extent to which they felt able to challenge the account of the complainant.[37]

There is slightly more data from the police officers and Support Worker. The Support Worker assessed the police positively in each statement-taking she observed and in a few cases noted "very professional" practice. Twenty-two police officers completed statement-taking log forms. Nearly three-quarters (73%, n=16) said the presence of the Support Worker made a difference to the process, especially with respect to providing 'support/advice/companionship' for the victim/survivor. Two officers also noted that, as they were male, it was positive to have a female presence.[38]

> *They can do the support and everything else while we do the writing. I mean some statements can be 30 to 40 pages long, if it's a lengthy statement, it can take anything up to eight hours… and after every twenty minutes we have to take a break 'cause they break down, it's a long drawn-out process and they get sick of it. They*

35 Forty-three of the 66 respondents completed questionnaires before the intervention was operational.

36 Fifty seven respondents said where they had made a statement.

37 It is not suggested here that there should never be any searching questioning of accounts by complainants, rather that the initial statement is not the appropriate point to do this, since there cannot have been a thorough investigation and weighing up of the evidence at this stage.

38 It is worth noting here that over half of interviewees whose initial contact and statement taking involved male officers noted this: some simply expressed surprise; others were critical of the practice, since in their view it created an unnecessary further barrier to being able to provide an account of a difficult and distressing event.

get bored with you and say, "I don't want to do it any more". And it's easier to have someone there who can do the support for you, because it's hard sometimes to switch out of police mode doing your statement, to caring, sharing, cup of tea person, and then switching back again, 'cause you lose your thread. I think it's good.

(St Mary's police officer, DC, F7, March 2003)

Analysis of the case-tracking database has been undertaken for this intervention using only those adults who reported to the police and made a statement. We have compared victim withdrawal rates for three periods: pre-intervention; post-intervention but no supported statement-taking and post-intervention with supported statement-taking. Combining the first two categories (see Table 6.3) shows that withdrawal rates are substantially greater where the Support Worker did not attend than when she did (53%, n=258 versus 20%, n=6), although the number of cases where this intervention took place are very small. There is, therefore, some limited support for this aspect of the Support Worker role. Lessons can be learnt from this pilot but will need to be adapted in light of the introduction of videoing testimony-in-chief under the provisions of the Youth Justice and Criminal Evidence Act, 1999.

Table 6.3: Level of victim withdrawals among St Mary's cases where Support Worker attended/did not attend statement

	Statement taken without Support Worker (n=487)		Statement taken with Support Worker (n=30)	
	No.	%	No.	%
Victim withdrawal	96	20	4	13
Victim declined to complete initial investigation	162	33	2	6
Total	258	53	6	20

Proactive follow-up

The Support Worker re-contacted all attendees of the Centre who consented to further telephone contact, amounting to 411 of the 834 service users (49% of the total and 61% of adults) during the evaluation period. There was an initial implementation gap, with the St Mary's staff team developing an 'opt-in' procedure. Whilst reflecting the client-led model that has characterised St Mary's response, this undermined the fundamental aim of the intervention – to test routine proactive contacting. The gap was highlighted by the evaluators in an interim report, alongside initial data from service users supporting the model, and

following lengthy discussions the intervention began to operate more systematically, whilst retaining an 'opt out' provision. This process reflects a tension in philosophies of service provision within the rape and sexual assault field, not just in the UK, but internationally.[39] The idea that victims/survivors should make choices about both reporting and service use draws on an analysis of rape as an exercise of power and control, and views 'giving it back' as a therapeutic exercise in empowerment. As far as known, this concept has never been empirically tested with service users, and has become something of an 'article of faith'. A section of the questionnaire to St Mary's service users canvassed their views directly and the majority of respondents (78%, n=48) supported routine proactive follow-up, though there was disagreement about the optimum time for the first re-contact: 37 per cent (n=17) suggesting within a few days, 33 per cent (n=15) after one week and 30 per cent (n=14) after a couple of weeks.[40] Interviewees provided eloquent and powerful challenges to the reactive empowerment philosophy, highlighting that this must be rethought in light of the importance and meaning attributed to support services (and other groups like the police) taking responsibility for maintaining contact.

> *In all this, you're dealing with so many people, yet they expect you to be able to – like the police expect you to be able to ring up and make phone calls. You're not in a position to make phone calls, you're not in a position to speak to all these different people, you're at your lowest point, and your most vulnerable… you don't want to be the one to chase people, you need it all there for you… I think the problem is, although it's available, they don't realise how easy it needs to be… not 'cause people aren't determined to get support, but because everything's hard work, when something like that's happened… I needed them to ring me. I can't emphasise enough that you're not in a position to do things for yourself. You can't go and find the help you need, you can't.*
>
> (St Mary's service user, Interview 11, Undetected)

> *Sometimes it's too much to ask somebody to contact. If you've been through a really traumatic experience, then it's a lot to ask somebody to contact you. You need to go to them, and offer the help. And if they turn you down, leave your name and phone number, and say, "Well if you ever do feel you need us, this is where we are." Because just that helps to know that somebody else cares, somebody else is on your side, and is prepared to listen. It takes quite a lot to ring somebody up and say, "I'd like to have some counselling, I've been raped." You know – you have to admit to yourself what happened first of all.*
>
> (St Mary's service user, Interview 7, Undetected).

39 It has also been evident in responses to domestic violence.

40 Later sections illustrate that this was one of the most common 'improvements' in services requested by respondents from all other research sites.

The kinds of support requested have been analysed through log forms (n=175) completed by the Support Worker with respect to 159 individuals. Unlike with the Domestic Violence Intervention Project (Burton, Regan and Kelly, 1998), where multiple attempts to make contact were evident, in almost all cases (95% of 73 cases where known) the Support Worker was able to contact the service user at the first attempt. In terms of resource implications, the relative ease with which contact has been made suggests that this intervention can be introduced fairly cheaply, and possibly even integrated into routine practice in a well-resourced SARC/advocacy project.

For over three-quarters of this group (79% n=125 of 159) current support needs were identified, in the main to talk through their situation. Other identified needs were counselling from St Mary's (n=20); face to face contact with the Support Worker (n=8); and more support from the police (n=5). The log forms and Support Worker interviews reveal that 'just having someone to talk to' conceals a multitude of practical matters and information needs, especially with respect to the progress of the police investigation and health concerns. The proactive and open-ended nature of the role means that the Support Worker has been able to respond flexibly to the variety of expressed needs, developing her own referral systems and networks to accommodate their requirements at particular points in time. Examples of the types of assistance are listed below, and reveal unmet advocacy needs that were not being addressed by existing St Mary's services, or at other SARCs, (with the exception of the period where some STAR service users have access to ISWs and the Case Tracker).

- Liaising with the police to both obtain and relay information on case progress.
- Facilitating/being present at further police contacts for the purposes of checking statement details or resolving communication issues.
- Liaising with Victim Support and other agencies on behalf of service users.
- Arranging for pregnancy tests, scans and terminations.
- Liaising with BT, to obtain a number change for a service user being harassed by the perpetrator.
- Assisting with housing issues, including arranging emergency accommodation.
- Liaising with employers[41] and family members.
- Writing letters of support to GP counselling services.
- Setting up and/or attending pre-court visits.

Although not envisioned as a case-tracking intervention, this proved to be one of the most frequently requested (and appreciated) actions undertaken by the Support Worker, within a broader context of support/advocacy.

41 In one case the woman was due to join the armed forces, and would not have proceeded without the reassurance the Support Worker was able to obtain that there would be no negative consequences. In fact the service was extremely supportive, making arrangements for the victim/survivor to attend court within her training.

> *The biggest part of the role I find is liaising between client and police. Because police just don't tell clients anything, you know. And even if they* [service users] *ring up, they won't get to the heart of it, whereas they* [police] *will tell me more. They tell me anything that I want to know. In fact, they're really, really helpful.*
>
> (St Mary's, support worker, F1, July 2002)

This intervention provides further support for the contention that in the immediate aftermath of sexual assault only a minority of service users are ready to take up counselling. Nonetheless, many need and accept more informal and practical support. This gap was recognised by a member of the St Mary's team at the start of the evaluation.

> *I think, again, from experience, that one of the first things that people want is help with other agencies, help with dealing with the practical issues, and will quite often want an advocate, somebody to liaise with external agencies… If it becomes more exploratory, more about the personal change – that's becoming counselling. If it's purely about the assault and the aftermath, then it's support.*
>
> (St Mary's, counsellor 2, January 2001)

The Support Worker has organised and attended six pre-court visits, and has supported eight clients through the trial process so far, with a further three where guilty pleas were submitted shortly before trial. In one of the trial cases, the victim would have had to attend court alone as her mother and sister were testifying as witnesses, and said that she would not have been able to withstand the ordeal of giving evidence without the Support Worker being there. Despite the fact that all but one of the trials resulted in acquittals, her presence was appreciated by both the victim and the police officers involved. One of these cases prompted GMP to send a letter addressed to the Clinical Director of St Mary's, acknowledging the 'important liaison between the victim and officers dealing with the case' that the Support Worker had provided, and the 'inter-agency co-operation' it represented. The work of the Support Worker in this regard differs from that offered by the Witness Service in that she is in a position to provide support from the time a report is made to an eventual trial, and is thus already in contact with those wishing to be accompanied to court. This reduces the level of exposure service users have to different practitioners, ensuring continuity with a trusted worker with whom a rapport has already been forged.

Analysis using the case-tracking database was undertaken to ascertain whether re-contacting had an impact on decreasing early withdrawals. Levels of withdrawal were compared between those who were re-contacted by the Support Worker and those who were not. Whilst on initial examination there was no discernable impact, looking in more detail at the

extent of contact the Support Worker had in the re-contacted cases revealed that those where this was sustained had lower early withdrawal rates. Of the 372 cases who reported to the police and were re-contacted by the Support Worker, the level of withdrawal fell from 30 per cent among those contacted once (n=65 of 216) to 20 per cent among those contacted between two and ten times (n=25 of 127). The importance of sustained contact was also evident in the stress placed by both questionnaire respondents and interviewees on wanting this from the police, and the disaffection that the lack of it resulted in.

These data demonstrate that proactive support was both welcomed and desired by victims/survivors: it was seen as an indication not only that there was someone who cared how they were, but also that the service understood how difficult it was to seek and ask for support. After considerable initial misgivings – as evidenced by the implementation gap – the staff team, having seen the intervention develop and having had access through interim reports to the views of service users, have become strong supporters of this new element in their response. So much so that one of the staff team who was most ambivalent initially, in her final interview commented that it was "unimaginable" for a new SARC being established without it. In recognition of the value and benefits perceived by GMP of both interventions, the Support Worker post was assimilated into the St Mary's recurrent funding formula after the CRP funding ended. After discussions at the end of 2003, and after distribution of the draft final site report, Victim Support are in discussion with St Mary's about the possibility of funding for a second Support Worker.[42]

Counselling

All three SARCs offer counselling. Sessions are provided on site at St Mary's and REACH by members of the SARC staff team, and throughout West Yorkshire, on a commissioned basis, by STAR. St Mary's provides unlimited counselling sessions, while REACH and STAR limit the number of sessions to a maximum of ten. This is primarily dictated by available funding, although additional sessions can be negotiated in certain limited circumstances. No counselling is directly offered in the Comparison areas, although the police provide victims with information on relevant support organisations.

All of the counsellors interviewed (n=15 [St Mary's n=2, REACH n=3, STAR n=10]) described their approach as either person-centred or client-led, although the types of training they had received differed. The descriptions of how they approached the work was similar with an emphasis on exploring thoughts and feelings, as well as enabling service users to regain a sense of control.

42 How this might operate, and where the worker would be located were still being negotiated at the time of writing.

First of all, I explain what I feel counselling is about… Counselling is about helping somebody deal with their thoughts, their feelings and their emotions about what has happened to them. Maybe looking at some goals… but most of all empowering you so you can carry on in your life in a positive way. So I explain my role, that I'm there to support them with whatever they want to deal with, and that the sessions are client-led, it's what they choose to bring to the session. So I work as a counsellor to empower women to take some choice and control back in their lives. I offer that. I offer that choice and control.

(St Mary's, counsellor, F1, January 2001)

I think all of us counsellors are very different. We've all had different training but I think we tend to be all very much person-centred and client-centred. It means working with the whole person. She's had no choice or control when she's been raped/sexually assaulted – she can actually have that control in the counselling room by being able to talk about whatever she needs to talk about. I feel that the person-centred approach empowers and that's what we're about and it gives that to the client.

(REACH, counsellor, F3, January 2002)

Analysis of the case-tracking sample shows that varying proportions of service users accessed counselling: REACH had the highest (61%, n=392), followed by STAR (40%, n=440) and St Mary's (35%, n=503). The higher proportion at REACH is partly accounted for by their higher rate of self-referrals who attend for counselling: the proportion of police referrals taking up counselling is roughly equivalent to the overall percentage at St Mary's (36%, n=134 of 374).

As with other aspects of service provision, over two-thirds of questionnaire (65%, n=55 of 85) respondents said that having a female counsellor was important to them, with similar reasons offered as noted in previous chapters, with the addition here that they felt women were more likely to understand their experiences.

Most questionnaire respondents and interviewees valued the opportunity to talk about the consequences of the assault to a professional disconnected from their circle of friends or family. Again there was more variability in responses from STAR service users, with a fifth of interviewees finding their counsellor unhelpful or judgemental; in two cases this was also connected to having to transfer to counselling when sessions with an ISW they had found extremely supportive and helpful ended.

I did go a couple of times for counselling, then I had, obviously, counselling about the STDs and there was a particular time just before I went to the HIV test, where I just went down and talked to one of the counsellors, and again she was absolutely smashing, you know. It's just that you panic, you know, I just panicked, and I just needed somebody to talk to, and they were there for me.

(St Mary's, service user Interview 6, Unreported)

It was amazing, because at the beginning I didn't know whether it would help. The first time I came, I think it was a relief, just to sit and talk to someone. I think especially to know that – it's all right talking to friends, and relatives, but because you're talking to somebody who's professional, who understands how you feel, a counsellor is definitely the best person to talk to. And because they're removed from it, because somebody who's close, you're aware of the effect on them. I mean, my mother would say to me, you know, "Just, you know, just tell me how you feel, just say whatever you want", but I felt as though I had to protect her to a certain extent. And with friends I think you're always aware of their reaction to what you're telling them. How they would judge you because of how you feel. So it was definitely a good thing, to have someone to talk to who, without knowing anything about them… I just put faith in her.

(REACH, service User, Interview 4, Unreported)

I can't remember how far it was, it was only probably three minutes' drive from where I'm living at the moment. I used to go there every fortnight… But the lady I saw was very supportive. Very understanding. And just helped me, really, in some ways, find myself, 'cause I'd forgotten who I was. Because I'd been put into this mould that my husband wanted, and been manipulated… You know, she helped me to realise, you know, that I'm a person in my own right, and that, you know, the past is the past, and put it behind you. You know, that, well, he's gone.

(STAR, service user, Interview 9, Unreported)

I think when I got referred on to a counsellor I had to go to her home. And I didn't like that. I'd prefer it if they'd come to us… [My ISW] *asked me if I'd like to go to a counsellor, and I agreed, just to see how it goes. But it didn't work… I didn't feel comfortable. She were a lot older than I expected. I'd say about 50, something like that… Someone like the Initial Support Worker that I had* [would have been better]. *Younger. In a better environment. And for them to ask me questions instead of waiting for me to say how I feel and stuff.*

(STAR, service user, Interview 7, Status unknown)

There were several deterrents to taking up counselling identified by the questionnaire respondents, the most common of which was that their immediate coping strategy was 'wanting to forget'. This was followed by a range of practical constraints, such as travelling distances and expenses, including childcare. Resolving these issues, and in the case of REACH and STAR, relaxing the limits on the number of sessions were the main suggestions for improving this area of service provision. Several respondents also disliked the 'client-led' approach, and wanted counsellors to take more of a lead in enabling them to talk.

Only REACH provides survivors support groups, which previous research has identified as particularly helpful in addressing issues of isolation and self-blame (see, for example, Burton *et al.*, 1998). Eight questionnaire respondents had attended groups and most valued them very highly, although two noted that they had not been 'ready' for it at the time. Only two of the 17 REACH interviewees had undergone group counselling but both viewed it positively.

> *It was nice to hear other people, 'cause you feel quite alone when you're doing like one-to-one and you think there's nobody else who's been through this, but then when you're in a group, you're hearing other people's stories, and then you automatically think 'Oh well mine's not as bad as all the rest in here', but then by the end of the sessions… we all decided that not one of us was worse or better off, we were all in the same boat… one of the women she'd been raped in South Africa, one of them was like child abuse from her father from years and years ago, it had happened for years and years, and another one, she was raped by her husband, in her marriage. So really all four of us was quite different. And I think that was quite nice, to be able to talk about your own experiences.*
>
> (REACH, Service user Interview 7, Acquittal)

Discussion and reflections

The data from services users show that a range of initial and ongoing support services were used and appreciated in the aftermath of rape. It is also evident that practical and advocacy needs feature strongly, especially in the period immediately following a recent assault, addressed currently by those who access ISWs at STAR and through the proactive support role added to provision at St Mary's. Whilst about a third of those dealing with recent rapes access counselling, a far higher proportion value being able to talk to someone in a supportive, but not strictly therapeutic setting, either over the phone or in face to face sessions. Case-tracking was also extremely important and valued by those who had access to it. Service providers, police officers and other key informants also recognised that in the immediate post-assault

period this flexible and informal support is what many victims/survivors need most. The data from St Mary's also offer support for moving towards proactive models, in which the SARC takes responsibility for initiating and maintaining contact.

This recognition of diverse needs sits alongside some unease amongst some of the SARC staff/service providers (primarily counsellors) who expressed concerns about the potential confusion across various roles, and the models of support in their local area.

> *There's been a lot less clients since the Initial Support Workers took over. Whether that's detrimental or not I don't know… But my own opinion, it's only my own opinion, I think it would be detrimental simply because the sooner they are able to unload, and I don't think they unload to an Initial Support Worker in the way they would do to a counsellor. I mean, I'm not devaluing Initial Support Workers, and I don't know enough about the work they do… it depends on the training. Somebody who has just done six weeks training going into somebody's home is less likely to be able to offer the same kind of skills that somebody who's been doing it as long as me can.*
>
> (STAR, counsellor, F8, December 2001)

> *Crisis work, support work and counselling. So the Crisis Workers do act as the client's advocate, and outline what we offer; the Support Worker's there to support the client during statement-taking and court, and anything else actually, and the counselling is about helping clients to explore their thoughts and feelings and emotions about what's happened and about setting goals… I suppose the question, really, is that what clients want? Do clients want a service that's delivered by three different faces?*
>
> (St Mary's, counsellor, F1, February 2003)

Though it may be possible to combine the Crisis and Support Worker roles at St Mary's in relation to any individual service user, this depends largely on staff availability and resources. A significant proportion of crisis work is conducted out of hours using a rota system, whilst support work entails re-contacting service users and liaison with other agencies, both of which must be conducted predominantly during office hours. This combination cannot, however, be extended to counselling due to the confidential nature of the counselling relationship. Whilst some St Mary's counsellors are also part of the crisis work rota, they would not offer both services to the same person.

Perhaps SARCs should attempt to offer the widest range of options possible, across three broad themes: initial crisis, informal support and advocacy and longer-term 'therapeutic'

work. The needs of service users are not static, and their personal circumstances also differ (access to transport, employment, mobility etc). The more possibilities there are to access support at times, and in forms, that suit them – and especially if the model is proactive – the more likely unmet needs will be picked up and addressed.

Whilst there are some obvious advantages to the decentralised model used by STAR, this brings with it significant challenges. They are the only SARC that has no initial face to face contact with victims/survivors and which uses a large pool of volunteers and sessional counsellors. Whilst the majority of service users assessed the service positively, there was more variation at STAR than the other two sites, suggesting that it is more difficult to ensure consistency and quality of responses in a decentralised model.

The importance of case-tracking, and associated advocacy, emerged as one of the most pressing and appreciated services SARCs provide for many who had reported the assault to the police. The evaluation process has provided an opportunity for the three SARCs to not just reflect on their own practice, but learn from good practice in the others. As the final data analysis was taking place REACH informed the researchers that they were instituting a new post, which would combine elements of the Case Tracker from STAR and Support Worker from St Mary's – a potentially fruitful integration highlighted in the second interim evaluation report.

7. Do SARCs make a difference?

In this chapter data from service users and professionals is drawn on to assess whether SARCs make a difference, and if so in what ways, since this was the fundamental question underlying the national evaluation.

The assessment of service users

A number of studies, and the interviews, note the inappropriateness of police stations in the process of reporting rape. The questions assessing initial responses to the two integrated SARCs contrast sharply with the busyness and lack of privacy of police stations. Both St Mary's and REACH were described as 'safe', 'reassuring' and 'private' locations. The need to 'feel safe' recurred in interviews across all sites, and integrated SARCs were much more able to provide this than other models. The few dissenting voices referred to the environment being 'too clinical' or having to wait too long to see a doctor.

> *It felt safe. I was just so frightened and so I didn't know what to do, and the doctor, she was so calm, and nice… And the room was warm and I just felt safe, I just thought, "Oh gosh, I've got home and I'm with somebody that's actually going to listen to me"… I just wanted to feel safe.*
>
> (St Mary's, service user, Interview 6, Unreported)

> *They were just brilliant. You just felt so supported and that they were there for you, and that they weren't making any judgements against you. Because the last thing you need at that time is somebody making judgements. Or somebody saying "Oh well, you know, it's a bit silly what you did." You don't need anybody telling you that… you're sitting there kicking yourself.*
>
> (St Mary's, service user, Interview 7, Undetected)

> *My experience was better than if there hadn't been a Centre there, because, if nothing else, the night I reported it, there was a Crisis Worker there that understood what I was going through. So if there's only one person that understands what you're going through, it's got to be better than nothing.*
>
> (St Mary's, service user, Interview 11, Undetected)

I can remember I burst into tears because there was this lovely, gentle voice on the other end of the phone. And I thought, "Finally there's somebody who cares"... I think a few days went by before I actually came in, by which time I managed to be terrified about coming in, because I didn't know what to expect at all. I think it all comes down to the trust thing... and I didn't trust anybody, and I think I got to the point where I was imagining that I'd been enticed in here by this lovely voice, and I was going to walk through the door, and I would be sort of forced into an examination and there'd be a policeman in the next room waiting to take a statement... I was relieved that when I came in there was no one here, and there's one thing that I thought was really good, that each time I came, there wasn't anybody else around. Because I would have felt really awkward to bump into people... but I thought it was so discrete.

(REACH, service user, Interview 4, Unreported)

Access to STAR is different, but on a range of measures there were very high approval rates from the majority of the questionnaire respondents (n=76-81, who answered the questions). A tenth overall, however, (11%, n=10 of 91) referred to initial responses being some combination of: disrespectful, judgemental and unhelpful.

As previous chapters have illustrated SARCs extend access to forensic and medical services, through the self-referral system. They also ensure that a significant proportion of service users can access a range of support services as demonstrated by Table 7.4 below, which documents the proportion of questionnaire respondents still in contact with the three SARCs, across the three time periods for the phased questionnaires.

Table 7.4: Proportion of questionnaire respondents in contact with SARC over time

SARC		Q1	Q2	Q3
St Mary's	Total number of respondents	66	23	20
	% in contact with service	52%	48%	20%
REACH	Total number of respondents	51	32	22
	% in contact with service	86%	41%	23%
STAR	Total number of respondents	91	59	36
	% in contact with service	86%	90%	22%

Whilst access is highest in the first six months, a fifth were still in contact almost a year later, even at STAR and REACH where the number of counselling sessions is limited. All but one of

St Mary's and REACH service users reported finding the contact useful, as did the vast majority of interviewees; whilst four-fifths of STAR service users were positive, there were slightly more dissenting voices here.

> *I think Manchester is very lucky to have a place like St Mary's. I had heard about it and was very grateful for the care, understanding and attention received. If I had had to go to a normal hospital I would not have reported what had happened. It's a godsend. NO MEN AROUND!.*
>
> (St Mary's Q1, 1051)

> *I just really found it really, really good. I mean, there was privacy, it was confidential, obviously they had to have some kind of contact details so they could get in contact with you… But it was brilliant, like I say, I just wish I'd known about this place sooner... I don't know about the immediate way they conduct themselves after an assault, or what the examination is like, but certainly the services I used were brilliant, I couldn't have asked for a better service.*
>
> (REACH, service user, Interview 6, Status Unknown)

> *STAR focused fully on… the aspects of the rape, not the actual details but how I felt afterwards, how I've coped over life, over my life, how I'm coping now with it, how I'm getting on with my life… I haven't found any fault with STAR at all yet. They're brilliant. And like I say, I'd recommend them to anybody.*
>
> (STAR, service user, Interview 5, Undetected)

A number of the questionnaire respondents had not used SARC services and revealingly the most common reason given across all sites (50% of the 56 who provided a reason) was wanting to forget, followed by having enough support from other sources. In the St Mary's area distance and transport were a barrier for some. Coping with sexual assault through wanting to forget has been documented previously (see, for example, Kelly, 1987), but a proportion are likely to seek support at a later point, either from a SARC or Rape Crisis.

SARC service users were referred to a range of external organisations, primarily Rape Crisis, Victim Support, the health sector, mental health services and other counselling facilities, either where more specialist help was needed or because time-limited sessions had been concluded. The responses received were generally good, although one of the main criticisms was that these services took too long to respond.

The improvements or additional services suggested across the three SARCs included: automatic/proactive follow-up; more groups with other survivors; access to support out-of-hours, especially in the evening; and self-defence classes. In both the STAR and REACH areas there was also a strong plea for easing the limits on the number of ISW and counselling sessions.

Comparison areas

Given the potential variability of sources of support in the absence of a SARC, a series of questions assessed whether, and what, support victims/survivors in these areas had access to. For this group the primary sources, and route to other support, were the specialist police officers. Whilst the number of research participants is small, far less support was accessed, and much higher unmet needs were evident, a number of which echoed those from respondents in SARC areas: proactive follow-up; support groups and self-defence classes. A strong theme here was also regular access to information on case progress from the police. The most likely additional support available to this group was Victim Support and Rape Crisis. Those who had made contact assessed these services positively, but a higher number reported long delays and even not being able to make direct contact at all.

One theme apparent in questionnaires and interviews in the Comparison areas was the number of women who felt they had had to cope with not only being raped, and the decision to report, but also being confronted with male professionals.

> *They should respond* [with] *a woman police officer, a woman doctor, and they should sit and listen to the victim… there shouldn't be no men involved whatsoever, in my view .*
>
> (Comparison Area, service user, Interview 4, Undetected

Towards the end of the questionnaire all respondents were asked from whom or where they had received the best support. The small number of respondents in the Comparison areas means these data can only provide an indication, but over three-quarters here (81%, n=9) referred to friends or relatives. Whilst this group also featured strongly in the SARC areas (St Mary's 53%, n=9; REACH 39%, n=11; STAR 47%, n=25), about a third overall rated the SARC most highly (St Mary's 18%, n=3; REACH 43%, n=12; STAR 25%, n=13).

What SARCs provide for professionals

The professional group that benefits most directly from a SARC are the police, since they provide forensic expertise, coupled with crisis intervention and ongoing support. Officers working in the St Mary's area are not specialists and have, over nearly two decades of its existence, come to rely on the Centre to provide support and other services to victims. In contrast, officers working in the REACH and STAR area are specialists and see themselves as providing a degree of support to victims. Whether specialist police officers should be focused primarily on victim care, as opposed to the investigation, remains an open question. However, where there are no specialist services, police undertake this by default, recognising the crucial importance of support. Despite these variations virtually all of the police officers interviewed placed a high value on their local SARC.

> *Once you've organised to go to St Mary's and you get them there, they just take over and do it all and that's the end of it. It's like you've got no worries about it. I mean I don't know what they must do at the other places where they don't have it, 'cause it's just, you know, it's set up, it's there, just sorted for you.*
>
> (St Mary's, police officer PC, F5, July 2002)

> *I think the relationship between St Mary's and the police is remarkably good considering the potential for friction. Let's not dodge the issue, when you're working in inter-agency fields, there is always the potential for friction. At the point at which we're providing that service to the victim we've got at least three disciplines, police, crisis workers and doctors. And what surprises me is how well that works. And I think it only works because there is a common agreement that what we're all here to do is provide some sort of service for the victim.*
>
> (St Mary's police liaison, January 2001)

> *I think that the SOLOs working here, I would say the majority of them have got nothing but praise for the REACH Centres because it takes a bit of a load of us.*
>
> (REACH, police officer CID/SOLO, F10, May 2003)

> *You know your complainant's being looked after by STAR.*
>
> (STAR, police officer CPO, F7, April 2003)

A small number of police officers and one CPS prosecutor also noted that by providing the opportunity for a forensic examination without an initial report to the police, SARCs are enabling some victims to report, and pursue a legal case, who would not otherwise have this possibility.

SARCs have a philosophy of allowing women to report an offence without any compulsion to report to police – women may be reluctant initially to speak to a cop but willing to explore reporting through professional help about [their] physical and mental condition and then might to able to talk to the police. In terms of CPS concerns, clearly if the complainant delayed reporting it would always leave the complainant open to attack regarding the genuineness of the complaint but with more liaison from SARC to police then the SARC would encourage genuine complainants to report. The point of the SARC was to influence increasing genuine reports, which is what the CPS wants to see.

(St Mary's, CPS, M1, March 2002)

The police liaison officer in Greater Manchester also pointed to ways in which a SARC can contribute to the development of good practice, and the identification of problems.

I think there's almost another level and that's the amount of feedback we get from doctors and counsellors, because they're not shy of ringing me up and saying "Just seen this victim and…" Now it's hard to see how we would get that feedback if we didn't have St Mary's… And it is incredibly valuable in making sure that that individual is getting as good a service as we can do. We all have to recognise that any public service is always going to fall down from time to time… but at least we've got a feedback loop to that victim via counsellors, via doctors, and they do use it. But I think above and beyond that, it helps us find system problems, [if] *there's the same problem cropping up from the same division all of the time.*

(St Mary's, police liaison officer, M1, January 2001)

There are strong parallels here with the Domestic Abuse Intervention Project in Duluth, Minnesota (Shepard and Pence, 1999) which co-ordinates responses to domestic violence. Good and effective inter-agency communication is a cornerstone of this model, and case-tracking is undertaken across all agencies to ensure that problems are identified and addressed promptly. This has acted as a rich resource in a 'problem-solving' approach to practice development. There is further potential to develop this in SARCs through an integrated case-tracking function.

A great deal of support for the SARC model was forthcoming from police officers in the Comparison areas: all of those interviewed (n=25) supported such services, although a very small number (n=3) had concerns about how it would work in a large rural force area.[43]

43 STAR is the principle existing UK model of a SARC designed to cater to the needs of this type of area. For examples of other models in rural areas see Kelly, forthcoming.

One expressed regret about the probable loss of ongoing interaction with victims that a SARC would result in, although four saw giving the support role to others as a positive thing.

> *Well I think that could work quite well. I mean sometimes you do get victims who become very dependent and needy for you, and it's very difficult, you know, ringing in the office all the time – it can be quite difficult. I suppose the advantage with that is presumably people could go, report a rape, have the medical done, and then decide whether they want to come to the police or not. They don't have to go ahead with it if they don't want to .*
>
> (Comparison 3, police officer DC, M2, June 2002)

> *Personally I would like to be able to take all my rape victims to the same place to have doctors there that are dealing with that kind of thing all the time, to have a support network there in place already.*
>
> (Comparison 3, police officer DC, F8, July 2002)

Victim Support and the Witness Service are the other agencies that SARCs have considerable contact with, and in the two areas with core support staff – STAR and St Mary's – a strong working relationship emerged whereby the strengths and capacities of each agency were being used to fullest potential for the benefit of service users. In fact, the Support Worker role has enabled a convoluted referral process[44] to be streamlined and more referrals to all four Victim Support branches in Greater Manchester have taken place since she has been in post.

> *We're working really closely with Victim Support. They do a lot more than help with criminal injuries forms. They'll get their locks changed… some have baby-minding services… We're feeding information backwards and forwards to each other.*
>
> (St Mary's, support worker, F1, July 2002)

> *I think the joint training and the joint work we've done with Victim Support has been absolutely first class and really paid off, and a lot of people have benefited from that service. Not everybody wants counselling, they want other things, they want practical hands-on support… I think that the Victim Support volunteers have been able to provide that in a much more flexible way and they tailor their service to what the client wants.*
>
> (STAR, management committee, F2, April 2003).

44 Victim Support do not contact victims of rape unless they receive their consent to do so in line with the guidance in Home Office Circular 44/2001. This required police seeking and getting consent, and then making that known to the local scheme.

SARC staff interviewed perceived the service they provide as complementary to local Rape Crisis Centres, where a large proportion of service users present for counselling to deal with rape or sexual abuse in childhood. Staff at the SARCs would refer any service user requiring support or counselling about historical abuse to Rape Crisis whilst also promoting local Rape Crisis groups as an alternative source of counselling for recent rape. Counselling sessions at both STAR and REACH are limited, thus service users needing long-term counselling may be referred to other local organisations including Rape Crisis.

> *I explain, "Yes, we have a counselling service, we can offer it", and they also say "Yeah, but I also want to work through child sexual abuse". I also say, "Right, we offer a service to women and men that have been raped or sexually assaulted. Rape Crisis offer a service to women who've been raped or sexually assaulted and for women who are survivors of child sexual abuse." What I also say then is "The choice is yours".*
>
> (St Mary's, counsellor, F1, January 2001)

Only a very small number of police officers (n=5) mentioned Rape Crisis as a potential source of support. The historic underfunding of Rape Crisis Centres, and the absence of a service in most of the Comparison areas, should be noted here. Few, if any, have had the extent or stability of resources currently available to SARCs, and this may account for some of the variability in service users' reports of attempting to access support through them, as well as local variations in referral rates.

Unintended consequences: case advocacy and inter-agency networks

All SARCs function as inter-agency projects, with the primary partnership being between the police and health. The forensic examination takes place alongside a medical examination and provision for emergency contraception and links for STI and HIV screening. That said, apart from involvement in management committees, inter-agency links on sexual assault are minimal when compared to domestic violence. In many areas RCCs and, where they exist, SARCs are members of domestic violence fora, but the focus of work rarely encompasses sexual assault in an integrated way.[45]

Although there is regular contact between SARC staff and police officers, in the main, this is limited to the practical necessities of individual cases. The organisation of much SARC work is not conducive to regular communication, since forensic examiners (and at St Mary's,

45 Exceptions to this are the networks in Lancaster and South Essex, which have followed government recommendations in Living Without Fear (Women's Unit, 1999), and transformed into violence against women networks.

Crisis Workers) work on rotas, and counsellors are bound by confidentiality. The advocacy roles of Case Tracker and Support Worker, and their presence in the SARCs during working hours, facilitate more regular and detailed inter-agency work and communication. The Support Worker role at St Mary's has evolved to the point where police officers now request that she accompany officers where they have to relay difficult information, such as cases being discontinued.

> *I've been involved with clients where the officer has said to me, "Look, you know, I need to go and see this client because, this is going nowhere"… Even then, when I've gone and we've sat and we've explained, even then I think they've* [the police] *been better. Now that could be because I'm there, you know, it may be totally different if I wasn't there, I don't know, but certainly I think clients are getting a better deal.*
>
> (St Mary's support worker, July 2002)

Both St Mary's and STAR provide further examples of how case advocacy – direct contact between workers from different agencies – can enhance not just referral processes but also 'joined up' responses (see also Kelly, 1999). Through regular contact, workers develop a clearer sense of their respective roles and expertise. This in turn means that the relevant 'basket of resources' (Sen, 1998) can be pulled together for individuals, with an advocate at the core.

Conclusions

At the end of this chapter the questions this evaluation was designed to address are discussed, and findings in relation to each one summarised.

- *How do these different variations of SARCs provide services?*

  This has been addressed in detail in the main text, with the main differences being an integrated centre-based model (St Mary's and REACH) and a non-centre framework facilitating access to localised support across a wide region (STAR). In addition, the range of services available varied and the CRP-funded interventions accentuated these differences. However, by the end of the evaluation period the three SARCs were exploring ways to learn from and integrate the good practice of the others, partly facilitated by the evaluation process and interim reports. This has culminated in the three SARC managers recently setting up a regular discussion group, where expertise and good practice are shared.

- *Do St Mary's, REACH and STAR deliver a speedy and effective service to victims of rape that treats them with dignity and respect?*

  All three SARCs were assessed positively by both service users and local police officers. The two integrated SARCs were best able to deliver a consistent standard and quality of service, including greater provision of female forensic examiners and limited delays in access to an examiner. Daytime examinations are an issue in all areas, but one of the SARCs resolved this shortfall through a forensic nursing pilot. The least effective model was where a third party is contracted to co-ordinate forensic services.

  All three SARCs deal with more cases than areas where there is no SARC because their availability is not just limited to police referrals. The additional self-referrals, who have often not reported, as well as referrals from other organisations in the case of REACH and STAR, mean the level of reporting to the service is higher, although this does not always translate into reports to the police.

  Data from service users revealed that the two SARCs with integrated forensic services were most able to conduct this sensitive process in ways that respected the complainant's dignity. This was the outcome of both internal protocols and building expertise in teams of female examiners. Assessment of other services showed that practice at all SARCs attempts to operate on principles of respect and care. However, there was slightly more variability in the area where a large number of volunteers and sessional counsellors provided the service.

- *Is there a consistent standard of evidence gathering and forensic reports?*

  The difficulties of accessing evidential material (police statements and forensic medical reports) in areas other than St Mary's means the data we have to assess this is limited, and only reports from St Mary's were analysed (see Appendix 2). There are undoubtedly more forensic medical examinations undertaken where there is a SARC. It is also clear that SARCs, where they have a dedicated, organised and integrated forensic service, display more consistent good practice. The response and attitude of forensic examiners were rated higher across all measures by complainants where such services were present, and the fact that they were female was welcomed. Such a model permits the implementation of clear protocols that seek to balance the needs of service users with those of forensic examiners and the criminal justice system. However, the absence of national minimum standards with respect to forensic examinations is noted.

The only issues about quality of evidence were raised by police officers in areas where the forensic services were contracted out. However, some issues about extraneous material were found in a few medical reports, and several police statements examined at St Mary's and STAR. Of particular concern were entries that potentially opened the way for the disclosure of sexual history evidence in any criminal trial, highlighting the need for national standards for evidence gathering in sexual offence cases.

The statement taking intervention, alongside data from interviews highlighting judgemental responses from (a minority) of police officers, suggests that there may be forms of inter-agency co-operation which can enhance confidence in the process, and through this gather better evidence.

- *Does the provision of counselling encourage take-up of follow-up support in the aftermath of sexual assault?*

  The levels of support evident at the three SARCs suggest that they encourage take-up of support in the aftermath of rape and sexual assault in a significant number of cases, and more survivors are able to access this due to the possibility of self-referral. Around a third took up initial/informal support where this was available, and between one and two-thirds across the three SARC areas accessed counselling. There was some evidence that proactive contact, either by the Support Worker or the Case Tracker, enables greater take-up. Further research would be useful to assess the longer-term impact of this provision. It was also apparent that the more forms of support that are available, the more likely they are to be taken up and that specific needs can be addressed effectively.

- *Do these services cater for the needs of victims/survivors?*

  Overall, SARCs were valued extremely highly by service users and many made use of a range of services. Areas that were particularly appreciated include: automatic provision of female examiners and support staff; proactive follow-up support; case-tracking and advocacy; and easy access through the telephone to advice and information. It is also worth noting that where any or all of these services were not available, service users identified them as gaps. There were also calls for more out-of-hours access, more support groups and self-defence classes.

The evaluation reveals that in the immediate aftermath of rape most victims/survivors want a more flexible and practical form of support, and relatively few are ready at this point to undertake counselling. A combination of support, advocacy and information on case progress were their priority needs. How these needs were met varied across the SARCs. Where there is limited or no specific support work these needs tended to be picked up by counsellors and specialist police officers but in an ad hoc and unco-ordinated way.

Both integrated SARCs had high quality facilities compared to the inconsistency evident in other areas, although there were suggestions for improvement.

Clear evidence emerged of greater control, especially over the forensic medical examination, in the two integrated SARC areas. The issue of control, however, becomes more complicated when the clear preference amongst a high proportion of service users for proactive contact is acknowledged.

- *Is there a significant difference between responses to victims/survivors in these areas compared to an area with no such service?*

  SARC services seek to combine the needs of survivors and those of the criminal justice system, whereas in areas without SARCs the latter tends to drive service provision. The development of services such as case-tracking and support/advocacy address long-standing gaps. Additionally, in areas where there is a SARC the range of support available is wider and the referral networks are more formalised, compared, for example, to the Comparison areas, where there is no official mechanism either for accessing specialist support or recording levels of take-up.

- *Is co-ordination between agencies in these areas enhanced?*

  This issue has been addressed in the previous chapter, and whilst this is the case, there are potentials for further development, especially using case-tracking and advocacy, that could be expanded; as could the extent to which sexual assault is addressed through existing fora, including domestic violence groups and crime and disorder partnerships.

  It is also noted that case-tracking and proactive contact mesh with government policy on vulnerable and intimidated witnesses, placing victims at the centre, rather than the periphery of criminal justice policy and practice (Home Office, 2003).

8. Cost effectiveness

SARCs long predated the CRP Violence Against Women Initiative, and whilst the new interventions they undertook were subjected to cost effectiveness analysis, this was not undertaken with respect to the SARCs themselves, as this was not considered a key aspect of evaluating them. There were two main reasons for taking this decision. Firstly, the majority of the costs of the SARCs were met from sources other than the CRP, and the CRP made no contribution to their core services. Secondly, the core date template, and that for assessing cost effectiveness designed by the Home Office was framed for domestic violence projects.

Most importantly it was evident from the outset that the argument for SARCs would have to made on grounds other than cost effectiveness, since they were inevitably going to be more expensive than the current alternative: rape examination suites and either a rota of forensic examiners organised by the police or purchase of such services from a provider, such as Healthcall. Moreover, the three SARCs in this study offered different services (see Chapter 2), to varying populations, and 'averaging' their costs would not have produced figures that could be meaningfully applied to any other context. In particular the integrated SARCs (St Mary's and REACH) provided follow-up medical tests, counselling, advice and support, but there was no simple way of assessing use of similar services in either the STAR area or the Comparison areas where there are no SARCs. The relative sparseness of the knowledge base on rape also meant that there was no proxy data that could be drawn on to estimate service use in other areas. Gathering data systematically[46] on service use from all the potential service providers, which might also be accessed by those living in areas where there is a SARC – at minimum, GPs and Health Centres, GUM clinics, Rape Crisis Centres, local counselling services, helplines, specialist police officers, Victim Support, law centres – would have been a research project in itself!

That said, it is worth making some overall points about SARCs and costs. Assessments of the worth and relevance of SARCs in any locality has be taken using criteria other than cost-effectiveness alone. Many of the areas where they have been recently established have based their arguments on the current poor service being offered to victims of rape, thus delivering on government commitments under the Victim's Charter, Vulnerable and Intimidated Witnesses Programme. The other commonly cited reason involves addressing the justice gap, especially the aim of increasing confidence in the criminal justice system and

46 This means number of contacts with victims/survivors of rape, services provided, time allocations and costs for that service and staff member.

decreasing attrition (Kelly *et al.*, 2004). Even here cost arguments are complex – since decreasing withdrawals, and increasing prosecutions will cost the public purse more in real terms, although it could also be argued that the previous investment in investigation has not been 'wasted', in the sense that increasing judicial disposal is a more satisfactory outcome. Care needs to be taken here, however, since the direct influence SARCs can have on attrition is relatively small (Kelly *et al.*, 2004) since the major factors accounting for it lie more directly within the criminal justice agencies – the police, CPS and courts.

In terms of enabling access to services a stronger argument can be made. SARCs ensure not only that a forensic examination is undertaken, but also that preventative services such as post-coital contraception and STI and HIV screening are taken up. The data on the health consequences of rape and sexual assault (World Health Organisation, 2002) also suggest that early intervention, especially where it is proactive, can limit the damage and impacts of sexual violence.

Perhaps most importantly SARCs represent a form of provision that can deliver procedural justice. A number of criminologists argue that victims are affected not only by ultimate outcomes, but also by the procedural aspects of their engagement with the criminal justice system. Amanda Konradi (2003), in relation to sexual assault, argues strongly that providing services that treat victims/survivors with respect and dignity is a vital element of procedural justice. This study confirms her contention, with victims/survivors finding the process far more difficult, even when a conviction was the eventual outcome, where they encountered careless and disrespectful treatment. Conversely, those who had been treated with care and respect, found negative outcomes, including acquittals in court, less devastating.

9. Future potentials and an 'ideal' SARC

During the course of this evaluation the three SARCs have built on existing good practice to extend their service provision, and the evaluation itself has revealed additional areas which victims/survivors identified as priorities and unmet needs. Within all service provision the critical issue of being treated with respect, and having the now legally encoded[47] rights to bodily integrity, privacy, and dignity, were paramount, and should form the foundation for both assessments of existing provision and any further developments.

This report concludes combining the good practice found in existing SARCs, the findings from the CRP evaluations of new interventions and basic principles to create a model of an 'ideal' SARC. Overall the evaluation showed that: the integrated model of providing forensic examinations on site is preferable to either of the alternative models; the emphasis in SARCs on counselling should be adapted to encompass more flexible, practical, informal support and advocacy, and adopt a more proactive approach. We also draw on research from other countries to highlight new challenges for existing SARCs.

One perennial challenge, which SARCs have begun to meet, is to increase the reporting of rape in order that victims/survivors can access medical treatment and other forms of support. The level of self-referrals in SARCs increases reporting to the service by almost a quarter (24%, n=749 of 3,172 across all SARCs), although currently relatively few of these translate into reports to the police. Amanda Konradi (2003) notes that recent research with college women in the US (n=4446, a national sample) confirms that the willingness to name a sexual assault is a real, not just a methodological problem. Young women in the late 1990s still operate with a narrow concept of what counts as rape, and are thus unlikely to report or seek support following sexual assault (see also, Fisher at al., 2003). Konradi (*op cit*) reports on an attempt by a US university to address this by using social marketing strategies to promote a forensic nurse project in the campus health centre. Both – locating a forensic nurse within university health centres and using social marketing to increase self-referral – are routes SARCs could consider expanding into.

One of the features of responses to violence against women in the UK (Kelly, 2000) has been the lack of integration between projects and services.[48] Provision in other countries has

47 These form some of the foundational principles of human rights, and as such can be found within the Human Rights Act, 1998.

48 This was also evident in the CRP Initiative, which despite encouraging applications that connected domestic and sexual violence, did not receive any applications that took this route.

developed, or is developing, more 'joined up' responses. The 'one-stop-shops' in Malaysian hospitals (originally modelled on St Mary's) provide forensic, medical, support and advocacy services across all forms of gender violence and child abuse, and this model can also be found in Central America. The SACs in Canada are also expanding to encompass domestic violence, and in some locales child sexual abuse (Kelly, forthcoming). Similarly SANE projects in the USA are rapidly extending their services to child victims and to domestic violence. Most of the global services surveyed for a World Health Organisation Project (*op cit*) supported this kind of integration, whilst noting a concern about losing a specialist focus on rape and sexual assault. The overview concludes asking whether it is possible to combine specialisation, integration and innovation, and this too represents a new challenge for SARCs in the UK over the next decade. Certainly in areas where the number of adult rapes per year would not justify a SARC, consideration should be given to whether a wider remit would garner greater support.

An 'ideal' SARC: a unified continuum of care

A recent task force in Michigan addressing the barriers to accessing services and justice for survivors of sexual assault concluded that 'a unified continuum of care' was needed (Lang and Brockway, 2003). This is what SARCs should seek to ensure and co-ordinate, and the model that follows draws on this concept and the findings of this evaluation. The model includes the best from each of the SARCs that took place in this evaluation, and each have contributed in some way to this vision of an 'ideal' SARC. We see this as the 'gold standard' that all SARCs should seek to emulate. At the same time provision needs to be adapted to local contexts; where there is no SARC currently interested parties should conduct an audit of likely annual referrals and existing services. These should then be linked to the outline template below in order to assess the resource and staff needs, and where they might be located. The 'checklist' can also be used as a way of improving local service provision incrementally, year-on-year, even where a physical SARC does not exist, and may be difficult to establish. For example, it may be possible to increase the availability of female forensic examiners through training a number of forensic nurses who can be located in hospitals across a large geographical region and it might be possible to commission proactive follow-up from existing local services such as Rape Crisis.

The model is organised around four main areas: the overall framework; range of services; forensic practice; and inter-agency links.

Overall framework

- Clear philosophical principles that emphasise respect, dignity, rights and choice.
- Privacy through the development of dedicated rooms with a single entrance, or a physical centre.
- An integrated model, where forensic examiners are located within it, although this could be delivered in more than one location.
- Clarity about who the service is for – adults who have been sexually assaulted is the usual model, but some are also accessible to adolescents, children and victims of domestic violence. Also, is the service limited to 'recent' assaults, and how is this to be defined?
- An explicit referral protocol with the police, which ensures all cases proceed as soon as possible to the SARC, and that a prompt response is guaranteed daytime, evening and weekends.
- A self-referral route that, if hospital-based, avoids the A&E triage system, since as most rape victims will not have serious injuries they will be deemed low priority.
- Attempts to increase and enhance access, including using social marketing strategies, websites and increasing links with under-served communities.
- Ensuring that even if there is a delay before a forensic examiner is available, a staff member is available to greet service users, take them to the more private rooms, and explain their rights and what may happen next. On-call 'crisis workers' would be the preferred method here.
- Whilst some staff will undoubtedly be engaged on a contract for services basis, for a SARC to function effectively there should be at minimum a paid co-ordinator/director, someone providing case tracking and proactive follow-up and at least one counsellor.
- The preference for female forensic examiners and support staff by both female and male survivors should be recognised, and female staff become the default position.
- Strong inter-agency ownership and management, based on shared financial input from statutory services and engagement with other local agencies, especially those with expertise in sexual violence.
- A commitment to data collection and case-tracking, alongside an interest in learning from information on service use and case outcomes.
- A mechanism for assessing the needs of service users through which their current levels of satisfaction are sought, together with a direct feedback loop into discussions about practice.

Range of services

- The option for self-referrals to have a full forensic examination (where the assault is recent), have samples stored, and pass on anonymised data to the police as intelligence.
- Crisis intervention, support and debriefing at first contact unconnected to the legal/evidential process.
- Forensic medical examinations.
- Medical treatment, preventative interventions and screening for STIs and HIV.
- Supported statement-taking.
- Routine proactive follow-up and advocacy.
- Case-tracking, updating on case progress and ensuring court preparation visits and accompaniment.
- Counselling.
- Flexible out-of-hours information and support.
- Support groups.
- Self-defence classes.[49]

Forensic practice

- Provided with minimal delay by female examiners who combine expertise in evidence collection with an ability to consult, inform and give control to the victim/survivor.
- Enhancing forensic practice through capacity building – both the number of trained examiners (possibly involving nurses) and their skills base, including use of a colposcope for documenting internal injuries.
- Processes adapted to the facts of the case, especially whether the evidential issues are likely to be identification of the offender (stranger rape) or consent (rape by known men). This should involve ongoing dialogue with the Forensic Science Service (see also Kelly, 2003).
- Protocols for the conduct of examinations, *pro formas* and body charts to ensure consistency in evidence collection and process.
- Training for forensic examiners in providing expert testimony – both in written form and in court.

49 The latter two might be provided through links with other services, for example, RCCs.

Inter-agency co-ordination

- Building a strong inter-agency partnership for the SARC, wherever possible including Rape Crisis Centres as key partners
- Building sexual assault as a specialism, through, for example, providing and taking part in joint training.
- Recognising and drawing on case advocacy as a route to developing inter-agency networks and the 'unified continuum of care'.
- Taking sexual assault into other inter-agency fora in the locality – for example, the Domestic Violence Forum and the Crime And Disorder Reduction Partnership.
- Using case-tracking data as a mechanism for identifying and solving system problems (see Shepard and Pence, 1999 for an example of this in relation to domestic violence).

Maximising potentials

Whilst many locations will not be able to establish an 'ideal' SARC from the outset, all new and existing SARCs should assess provision paying particular attention to the priorities and needs identified by service users in this study. Across the six research sites there was remarkable equanimity about the parameters of good and bad practice, and what made a positive difference to the inevitably difficult process of reporting, and/or seeking support following, rape. This is the largest and most extensive study of these processes to date in the UK, demonstrating that whilst the integrated SARCs scored highest on a range of measures, even they have room for improvement.

The potentials of SARCs could be maximised even further if the strong steer from government extends beyond promoting the idea of SARCs to encouraging their ability to deliver consistency and high quality. It is hoped that this will be an area the recently formed Inter-Ministerial group on Sexual Violence will seek to address. Two areas which need urgent attention are establishing minimum standards for training of forensic examiners in this specialist area and developing, with interested parties, national standards for the examinations, their documentation and the content of court reports. This would serve multiple purposes: it would establish the need to adapt practice to the facts of the case and possible defences; it would preclude the potential entry of sexual history of the complainant into evidence through the forensic report; and it would establish sexual assault as a specialist area of forensic medicine.

SARCs have the potential to deliver services to victims/survivors of recent rape, and to the criminal justice system, overcoming long-standing gaps in response, which have been described as elements in procedural justice. On this basis they should be supported and extended. They should not, however, be seen as an answer to either the attrition rate or the chronic lack of support services with respect to rape and sexual assault in the UK, and most particularly in England and Wales. Investment in, and support of, SARCs is a welcome first step from government, but the journey to ensuring that those who have had the most intimate of boundaries violated receive the kinds of support they need and want, at the points where it is relevant and appropriate for them, has just begun.

Appendix 1: Comparative profile of all six study sites

Profile	Greater Manchester	Northumbria	West Yorkshire	Brent	Newham	Thames Valley[1]
Total population[2]	2,482,328	1,383,128	2,079,211	263,464	243,891	2,091,689
People aged 16-74	1,781,882 (72%)	1,009,986 (73%)	1,489,740 (72%)	198,712 (75%)	170,268 (70%)	1,528,836 (73%)
Ethnic origin						
White	2,260,507 (91%)	1,346,183 (97%)	1,842,813 (89%)	119,278 (45%)	96,130 (39%)	1,914,756 (92%)
Black and other minority ethnic	221,821 (9%)	36,945 (3%)	236,398 (11%)	144,186 (55%)	147,761 (61%)	176,933 (8%)
Geographical area	1,276 sq.Km	5,553 sq.Km	2,029 sq.Km	43 sq.Km	36 sq.Km	3,520 sq.Km
Area type	Metropolitan	Urban and rural	Urban and rural	Metropolitan	Metropolitan	Urban and rural
Reported rapes 2001[3]	542	269	406	105	93	286
Cases in study sample 2001[4]	351	144	339	62	34	57
Proportion of reported rapes 2001 in study sample	65%	54%	83%	59%	37%	20%

Notes

1 The area covered by Thames Valley Police spans parts of the three counties of Berkshire, Buckinghamshire and Oxfordshire, but does not correspond exactly with local authority or county areas as used by the UK Census 2001. Data from Aylesbury Vale, Bracknell Forest, Cherwell, Chiltern, Milton Keynes, Oxford, Reading, Windsor & Maidenhead, Slough, South Bucks, South Oxfordshire, Vale of White Horse, West Berkshire, West Oxfordshire, Wokingham and Wycombe have been aggregated here to represent the closest possible replication of the area served by this police force.

2 Source for population, age and ethnic origin and geographical area for all sites: http://www.statistics.gov.uk/census2001/.

3 2001 has been selected as it is the first full year of the study. Figures on reported rapes in Greater Manchester, Northumbria, West Yorkshire and Thames Valley from Home Office data, cover the calendar year 2001. Figures on reported rapes in Brent and Newham from Metropolitan Police Rape/Sexual Offences Statistics Package cover the financial year 2001/2002.

4 This is the number of individuals at each site we have recorded on our case-tracking database who made a report of rape to the police. This has been calculated for the calendar year 2001 for Greater Manchester, Northumbria, West Yorkshire (see above note); for Brent, Newham and Thames Valley our data collection began on 1st September 2001, so the figures presented relate to the period of a year from 1st September 2001-31st August 2002.

Appendix 2: Research tools and data sources

Case-tracking database

The case-tracking database was created specifically for this project using Access software to include details on all cases referring to the three SARCs and reporting in the comparison areas. Every individual entered on the database has a record consisting of a header and a series of linked forms. The header contains: the unique reference number; research site; referral type; and details of participation in the evaluation. The linked forms and fields within them focus on:

- *Details of the assault* – date and time it occurred, location, type and additional details.
- *Details of the victim* – age, sex, ethnic origin, disability, relationship profile and employment status.
- *Details of the perpetrator(s)* – age, sex, ethnic origin, disability, employment status, relationship to the victim, length of acquaintance and whether a weapon was used.
- *Forensic examination* – date and time, examiner type, whether injuries were sustained, whether drugs/alcohol were involved and which samples were taken.
- *Service use* – type of service accessed at each site.
- *Police report* – date and time reported, who reported, whether a statement was taken, whether a suspect was identified, arrested and held in custody, CPS advice, reasons for cases not proceeding and additional details.
- *Legal process* – final police classification, whether the case went to court, plea, trial outcome and sentence.

The level and type of data recorded, as well as the recording systems in place, varied at each site. Consequently, different processes for obtaining the information required for the case-tracking database were employed at the six sites. STAR has its own database that contains many fields comparable to those in the case-tracking database. Because STAR has a Case Tracker who informs service users of case progress if they have reported the database contains detailed information on case outcomes. Here, copies of the STAR database were anonymised by removing the names and contact details of the service users and periodically downloaded for the research team. In the three comparison areas all data were supplied by the police. At St Mary's and REACH there were varying degrees of

reliance on the police for elements of data, such as details of the police report, perpetrator details and legal outcomes. This information was obtained by distributing two *pro formas* to police officers, one within a month of the initial police report and the second up to a year later. In a number of cases multiple follow-ups were needed both to recover outstanding *pro formas* and to obtain complete information on cases that had not been completed at the time of returning the second *pro forma*. The remaining details on victims, forensic examinations and service use were provided by the SARCs.

Service user questionnaires

All those included on the case-tracking database were potential participants in this element of the research. Three phased questionnaires were distributed to those service users who agreed to take part at the first, fifth and twelfth month after their initial contact with the SARCs or report to the police in the comparison areas. The questionnaires were adapted to reflect the processes and available services at each site, whilst retaining a common core to ensure comparability. They were also designed to be applicable to those who had reported to the police and those who had not. The questionnaires were referenced using the unique reference number to enable linking them to cases entered on the case-tracking database. The areas covered in each of the questionnaires were:

Questionnaire 1

- *About you* – age, ethnic origin, disability, relationship profile, employment status.
- After the assault – did you tell anyone about the assault before reporting to the police and what was their response?
- *Reporting to the police* – did you report to the police, reasons for reporting, how long after assault was the report made, how was the report made, your state of mind when reporting, how would you rate the response of first police officer you spoke to, satisfaction with the police at this stage, any suggestions for improving the initial police response?
- *Crisis Worker* (St Mary's only) – how you understood their role, sex of the Crisis Worker, did this make a difference, how would you rate their response, satisfaction with Crisis Worker, how much information did they give you about the next stage of the process?
- *Specialist police officer* (REACH, STAR and comparison areas only) – did you see one, when did you see one, how you understood their role, sex of the officer, did

this make a difference, how would you rate their response, satisfaction with specialist officer, any suggestions for improving the response of specialist officers.

- *Forensic medical examination* – did you have one, did you have to wait to see examiner, feelings before the examination, sex of the examiner, did this make a difference, was the process of the examination explained, how you experienced the examination, how would you rate the response of the examiner, satisfaction with examiner, any suggestions for improving examinations?
- *After the forensic medical examination* – contact with specialist officer/Crisis Worker after the examination, how would you rate their response?
- *Making a statement to the police* – did you make one, when did you make one, where did you make one, were you given a choice about the timing and location of the statement-taking, feelings before making a statement, sex of the officers present, did this make a difference, how you experienced making a statement, how would you rate the response of the officers taking the statement, were you given information about the next stage of the process, have you had any contact with the police since the statement, any suggestions for improving the statement-taking process?
- *Use of services* (SARCs only) – which services have you used so far, how would you rate the response of the service provider, any suggestions for improving the service, were there any services you needed that were not provided?
- *Your decisions and the future* – are you intending to pursue the criminal case, if not, why, how are you coping at the moment, what are you finding difficult?
- *About the questionnaire* – are there any additional questions we should have included, how have you found completing the questionnaire, any additional comments?

Questionnaire 2

- *About you* – how are you coping at the moment, what are you finding difficult, are there any areas where you need support?
- *Take-up of services* – have you been in contact with the SARC since completing initial questionnaire, has this been helpful, which services have you accessed, how would you rate the response of the service provider, were you referred to any other services by the SARC/police, how would you rate their response, have you received any support from family or friends, who has provided the best support so far?
- *Contact with police* – have the police been in contact since completing the initial questionnaire, what about, how would you rate their response, how well have you been kept informed about their case, is there anything more the police could have done?

- *Criminal case* – do you know the current status of the case, if yes, what is it, what are your views on the outcome?
- *About the questionnaire* – are there any additional questions we should have included, how have you found completing the questionnaire, any additional comments?

Questionnaire 3

- *About you* – how are you coping at the moment, what have you find most difficult over the past year, are there any areas where you need support now?
- *Take-up of services* – have you been in contact with the SARC since completing the second questionnaire, has this been helpful, have you been in contact with any other services since completing the second questionnaire, what was their response, how would you describe your overall experience of support services over the past year, could anything have been done differently to support you more?
- *Contact with police* – have the police been in contact since completing the second questionnaire, what about, how would you rate their overall response since you reported the assault, could the police have done anything differently to support you more?
- *Criminal case* – has your case been heard in court, if no, what is the current status, if yes, what was the outcome, did you meet the Prosecution barrister, did you give evidence, what was your experience of giving evidence, what are your views on the outcome, how would you describe the overall experience of going to court, is there anything that might have made the experience of going to court easier?
- *About the questionnaire* – are there any additional questions we should have included, what has it been like taking part in this research, any additional comments?

Service user interviews

All service users participating in the questionnaire element of the research were also invited to take part in an interview, either face to face or over the telephone. This was to gain more detailed qualitative information on their experiences of service use and the criminal justice process. For face to face interviews participants were given a choice of locations, including the SARC, their own home and counselling premises. A letter explaining what taking part in the interview would

involve and a return form were distributed with the second of the three service user questionnaires. The interviews were semi-structured and slightly adapted in order to be relevant to service users at the different sites. Interview transcripts were anonymised and referenced using the unique reference number so they could be linked to completed questionnaires and the case-tracking database. All interviews covered the following broad themes:

- Decision-making about reporting to the police.
- Experience of initial contact with the police.
- Experience of contact with the SARC.
- Response of Crisis Worker/specialist police officer.
- Experience of forensic medical examination.
- Experience of giving a statement to the police.
- Follow-up contact/support from the SARC, police and elsewhere.
- Decision-making about the legal process.
- Current status of the case.
- How they are feeling/coping.
- Comments on the process so far.
- What victims of rape/sexual assault need. How did their experience compare with this?
- How the process could be improved.

Witness statements

A sample of witness statements made by victims to the police in the SARC areas was obtained. It was not possible to acquire a random sample of statements for two reasons. Firstly, to avoid disclosure that might affect any proceeding case, researchers were only allowed access to statements in completed cases. In addition, SARC managers requested that they had consent from service users to access this material, so they were limited to cases where the victim/survivor had opted into the evaluation and/or gave permission for the statement to be disclosed. All statements received were anonymised, with the complainant's name removed, and were coded with the unique identifier so they could be linked to the other data sources.

Forensic medical reports

Different protocols were negotiated at each SARC site for accessing forensic medical reports, largely reflecting the varying systems for conducting examinations. At St Mary's copies of all forensic medical reports are stored centrally. Here, all cases where a forensic examination was conducted during the evaluation period were grouped according to examiner type (female doctor or forensic nurse) and then according to final police classification (no crime, undetected, detected, no proceedings and detected). Random sampling was then conducted within these groups and a roughly equal number of reports selected from each. At REACH and STAR consent to access these documents was sought from service users directly in the same way as for the witness statements (see above), meaning the sample size was more limited. Reports relating to participating service users at REACH were sought from the individual forensic examiners, as they retain all documentation relating to the examinations they have conducted. In the STAR area, where the SARC does not control the conduct of forensic examinations, lengthy negotiations were held with Heathcall, the contractor used to supply forensic examinations in West Yorkshire, regarding access to forensic medical reports. Unfortunately, no reports were forthcoming by the end of the evaluation from this area. All forensic medical reports received were anonymised, removing both the service user and forensic examiner's names, and referenced with the unique identifier to enable cross-referencing with the case-tracking database and other data sources.

Interviews with service providers

Phased semi-structured interviews were conducted with SARC staff (management, counsellors, crisis workers, case tracker and support worker and forensic medical examiners) and key players (police officers, Crown Prosecutors and Victim Support). At St Mary's interviews were conducted at three stages during the evaluation – at the beginning, at a midpoint and at the end. In the REACH and STAR areas interviews were conducted at a midpoint and at the end of the evaluation. In the comparison areas senior officers were interviewed at a midpoint and at the end of the evaluation, whilst investigative officers and police chaperones/specialist officers were interviewed once.

For SARC staff the interview questions covered the following themes:

- Role in and length of involvement with SARC.
- Contribution of SARCs.
- Any noticeable changes while they have been in post in the type of rape/sexual assault cases they see.
- System for providing forensic examinations.
- Reasons why rape/sexual assault is under-reported.
- Reasons why complaints are withdrawn.
- Reasons why cases are lost later in the criminal justice process.
- Progress and impact of CRP-funded interventions.
- Inter-agency links.

The views of police and other key informants were sought on the following areas:

- Outline of role.
- Connection with SARC.
- Contribution of SARC and services provided.
- Service offered by police to rape/sexual assault victims in area.
- System for providing forensic examinations.
- Reasons why rape/sexual assault is under-reported.
- Reasons why complaints are withdrawn.
- Reasons why cases are lost later in the criminal justice process.
- Progress and impact of CRP-funded interventions.
- Inter-agency links.

Appendix 3: Response rates to initial service user questionnaire

	St Mary's		REACH		STAR		Comparison	
Total referrals/cases	1,442	100%	638	100%	1,092	100%	355	100%
Invited to participate in evaluation[1]	716	50%	483	76%	829	76%		
Consented to receive questionnaire pack[2]	343	24%	69	11%	142	13%	37	10%
Returned completed questionnaire[1]	66	5%	51	8%	91	8%	20	6%
Response rate as proportion of those invited[3]	9%		11%		8%			
Response rate as proportion of those who consented to receive questionnaire pack	19%		74%		64%		54%	

Notes

1 At STAR people under 16-years-old (STAR 11% of all referrals, n=125) were excluded from the evaluation as they were the subjects of a separate evaluation of a CRP-funded service for young people. At St Mary's those under 16-years-old formed a notable proportion of all service users (St Mary's 18% of all referrals, n=266) and were also not invited to take part due to ethical issues and the question of parental consent. Self-referrals were also excluded until late in the evaluation (22% of total referrals, n=313). These two factors accounted for the difference in the lower numbers of St Mary's service users invited to participate in the evaluation. An additional number of service users at all the SARC sites were not invited either due to other reasons of vulnerability (mental health, learning disability, lack of safe contact address, language) or because the staff member omitted to ask them (St Mary's 8% of all referrals, n=122; REACH 24% of all referrals, n=155; STAR 13% of all referrals, n=138). Unfortunately, police officers in the Comparison areas did not record details of whether or not individual complainants were informed about the evaluation. It is, therefore, impossible to calculate the proportion invited to take part.

2 The difference in the proportions of service users who consented to receive the questionnaire pack is probably reflective of the different protocols for engaging potential participants employed at the three SARCs and in the Comparison areas. At St Mary's consent was sought verbally via the Crisis Worker during first attendance, whereas service users at REACH and STAR and complainants in the Comparison areas were sent written information by the SARCs or police and asked to complete and return a form if they wished to take part. It is possible that being asked to consent to receive the questionnaire pack at the same time as being provided with information on services and options elicited a higher number of positive responses at St Mary's, although these did not translate into an equally high number of completed returns. The REACH and STAR protocol, which gave potential respondents time to consider their involvement, appeared to bring about less agreement to receive the questionnaire pack, although it increased the proportion of completed returns. This difference is particularly marked when the number of completed returns is calculated as a proportion of those who consented to receive the questionnaire pack.

3 Not possible to calculate for the Comparison areas.

Appendix 4: Comparative analysis of SARC service users and Comparison area cases

	St Mary's		REACH		STAR		Comparison	
Total referrals/cases	1,442	100%	638	100%	1,092	100%	355	100%
Sex								
Female	1,332	92%	586	92%	1,018	93%	346	97%
Male	110	8%	52	8%	74	7%	9	3%
Age								
Under-16[2]	266	18%	-	-	125	11%	-	-
16-25	630	44%	313	49%	504	46%	147	41%
26-35	305	21%	156	24%	235	22%	110	31%
36-45	163	11%	94	15%	153	14%	59	17%
46 and over	71	5%	42	7%	57	5%	27	8%
Unknown	7	1%	33	5%	18	2%	11	3%
Ethnic origin								
White	1,127	78%	549	86%	848	78%	222	63%
Black & other minority ethnic	110	8%	26	6%	81	7%	120	34%
Unknown	205	14%	53	8%	163	15%	13	3%
Referral type[3]								
Police	1,048	73%	374	59%	739	68%	355	100%
Self	380	26%	175	27%	180	16%	n/a	
Self then police	13	1%	0	0%	1	0%	n/a	
Other	0	0%	89	14%	172	16%	n/a	
Unknown	1	<1%	0	0%	0	0%		
Proportion students	438	30%	44	7%	145	13%	36	10%
Proportion with a disability	66	5%	23	4%	85	8%	19	5%
Proportion involved in prostitution	31	2%	2	0%	31	3%	4	1%

(Continued overleaf)

	St Mary's		REACH		STAR		Comparison	
Number of perpetrators								
1	1,269	88%	598	94%	1,012	93%	320	90%
2 or more	168	12%	40	6%	65	6%	34	10%
Unknown	5	<1%	0	0%	15	1%	1	<1%
Sex of perpetrator								
Male	1,436	99%	634	99%	1,085	99%	355	100%
Female	3	<1%	1	<1%	4	<1%	0	0%
Male and female	3	<1%	3	<1%	3	<1%	0	0%
Relationship of perpetrator to victim[4]								
Known	630	50%	297	50%	612	60%	165	52%
Recent acquaintance	129	10%	82	13%	87	9%	13	4%
Stranger	313	25%	119	20%	203	20%	110	34%
Unknown	197	15%	100	17%	110	11%	32	10%
Proportion where perpetrator 'known' by referral type[5]								
Police	454	54%	169	54%	428	66%	165	57%
Self/other	176	74%	128	70%	184	74%	n/a	
Proportion of where assault outside UK by referral type								
Police	2	<1%	2	<1%	3	<1%	0	0%
Self/other	37	10%	2	1%	31	17%	n/a	
Proportion reported to police	1,071	74%	380	60%	837	77%	355	100%

Notes

1 All data from case-tracking database.

2 Those under 16-years-old not catered for by REACH and not part of data collection in Comparison areas. Officers here advised against this because of ethical issues and parental consent.

3 Referral type is referral to the SARC so analysis by referral type other than police is not applicable in the Comparison areas.

4 For cases involving single perpetrators only (St Mary's n=1,269, REACH n=598, STAR n=1,012, Comparison n=320). The relationship categories used here are: known (including partner, ex-partner, family member, friend, colleague, neighbour, professional or acquaintance); recent acquaintance (contact within the previous 24 hours or less); and stranger (no previous contact).

5 Calculated as a proportion of referral type only for cases involving single perpetrator and where details of relationship between perpetrator and victim known (St Mary's police n=834, self/other=239; REACH police n=315, self/other=183; STAR police n=652, self/other=250; Comparison police n=288). For Comparison areas all cases are police as there is no self-referral option.

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