SERIES

Sexual assault: key issues

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This is the first in a series of articles on sexuality and sexual health.

INTRODUCTION

Sexual assault is both a common and a very serious crime which is investigated by the police with an intensity second only to that of murder.

In total, 62 081 sexual offences were recorded by police in England and Wales in 2005/2006, of which 14 449 were offences of rape[1]—representing a significant increase in reporting compared with the 1842 such reports in 1985.[2] In 2006 a 3% increase in women reporting rape (12 903 to 13 331) was noted, compared to a 2% decrease among men (1139 to 1118). In spite of the overall increase in reporting over the years, the conviction rate for rape remains persistently low: under 6% in England and Wales and only 4% in Scotland.[3]

Many blame an ambivalent public attitude to rape, as suggested by the Amnesty International report of November 2005,[4] which showed that a third of people believe that a woman may be partially or completely responsible for being raped if she has behaved flirtatiously, and that 25% of the 1000 people surveyed believed a woman is at least partially to blame if she has worn revealing clothing or been intoxicated. Most people surveyed had no idea how many women were raped every year in the UK.

The true reasons for low conviction rates in rape cases are complex and cannot be explained by this 'rape myth' alone. The real problem lies in the high attrition rate, with only 14% of reported cases resulting in trial proceedings. About 9% of cases are classified as false allegations, the majority of which are reports from within the 16–25 age group. One third of reported cases fail to proceed past the investigation stage due to 'evidence issues' or 'victim credibility'. Another third are lost when the victim later withdraws from a case for fear either of being disbelieved or of the criminal justice system or court process. The fact that majority of assailants are known to the victims and that a large numbers of cases are associated with drinking alcohol completes the picture.[3,5–7]

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CONSEQUENCES OF RAPE

Rape can have devastating psychological consequences on victims, culminating in Post Traumatic Stress Disorder with an array of symptoms, including sleeping difficulties, poor appetite, flashbacks, feelings of numbness, anger, shame and denial, avoidance behaviour, and relationship and sexual difficulties. In the most severe cases, depression can leads to suicidal ideation and suicide.[8]

Apart from psychological symptoms, there are health consequences to consider, such as physical injuries, sexually transmitted infections (STIs) including HIV and unwanted pregnancy. There can also be substantial negative impacts on partners or family.

Physical injuries can be severe, sometimes life-threatening, but this is rare and most physical injuries resolve within several days. Fear of STIs and fear of pregnancy represent the two most common reasons for seeking help at different medical settings immediately after rape.

THE VULNERABLE VICTIM

There are many ways in which a person may be vulnerable to sexual assault. Many victims are vulnerable because of their age, particularly at the extremes, with adolescents being one of the biggest group of sexually assaulted individuals; about 20% of victims have a history of mental health problems, self-harm or learning difficulties;[9] and many assaults occur as part of domestic violence.[10] Fifty percent of women and 35% of men in the latter category had experienced more than one type of intimate violence since the age of 16. Further adding to the complexity is rape amongst ethnic minorities, with cultural issues, language barriers and limited knowledge of personal rights having an impact on reporting.

RAPE AND THE LAW

In order to keep pace with the changing nature of rape, a new Sexual Offences Act became law in 2003, replacing the old Sexual Offences Act 1956.

The new Act, amongst other things, deals with the issues of free consent, recognizes oral penetration with a penis as rape alongside penetration of the vagina or anus, treats any sexual intercourse with a child under the age of 13 as rape and defines the age of consent as 16.[11]

INVESTIGATION AND PROSECUTION OF RAPE

Treatment of the rape victim by the police has been heavily criticized in the past. In view of the criticism, under-reporting of rape and low conviction rates, methods have changed, with some forces forming specialist units dedicated to the investigation of rape.

In January 2001, for example, the Metropolitan Police set up a specialist Sapphire Unit in each borough of London, employing officers who are highly skilled and trained in rape investigation using the Sexual Offences Investigative Technique (SOIT). The Sapphire strategy addresses intelligence, investigation, targeting, diversification and forensics.[12]

The Rape Action Plan was established in July 2002, putting forward eighteen recommendations and three suggestions for action to the police and the Crown Prosecution Service (CPS), including facilities for forensic examination, training for police officers, specialist rape prosecutors, guidance to barristers and special measures for victims in court.[13]

Most recently, in 2007 a report entitled *Without Consent* was published following a review to assess progress against the Rape Action Plan 2002. The report acknowledges that considerable efforts have been made, but that many challenges still remain to be met.[14]

SEXUAL ASSAULT REFERRAL CENTRES

A Sexual Assault Referral Centre (SARC) is a model of service dedicated to addressing the forensic, evidential and aftercare needs of victims of sexual violence.[15] SARCs are examples of a multi-agency partnership with the potential to improve health outcomes as well as criminal justice outcomes for victims of rape or sexual assault. This model has been promoted by the Home Office as the gold standard.

The first SARC in the UK was set up at St. Mary's Hospital in Manchester in 1986. There are now 13 SARCs in the UK, mostly in urban areas, including the three Havens in London: Camberwell (founded in 2000), Paddington and Whitechapel (founded in 2004), as well as the Juniper Centre in Lancashire, the REECH Centre in Northumbria and the New Pathways in South Wales.

Funding for the SARCs comes either solely from the police or from the police and health care organizations, mainly Primary Care Trusts. Home Office, non-statutory organizations or charitable donations also contribute to the upkeep of SARCs.

The minimum requirements for a SARC service include: a dedicated secure facility integrated with hospital services; availability of forensic examination 24 hours a day, within four hours of disclosure; facilities for non-police referrals; crisis workers to support the victim; immediate aftercare, such as emergency contraception and prophylaxis against infections; follow-up services, including screening for STIs; and psychosocial support.

NON-SARC SERVICES

Another model of existing service provision in a non-SARC model relies on dedicated forensic physicians carrying out forensic examinations of complainants of sexual assault independently, at the request of the police, in Victim Examination Suites located in police stations.

A recently published survey of SARC and non-SARC settings highlighted some disproportion in service provision, with the non-SARC services not offering forensic examination without police involvement and many not having enough specially trained doctors to offer a 24-hour service. Most non-SARC services do not offer screening for STIs or prophylactic treatment.[16]

MEDICAL, FORENSIC AND PSYCHOSOCIAL CARE FOLLOWING SEXUAL ASSAULT

Following sexual assault, victims have three main care needs: forensic, medical and psychosocial.[17,18] Forensic examination is carried out as soon as possible after the assault unless medical reasons take precedence, to gather forensic DNA evidence and to document injuries. On average, a case of sexual assault takes two hours to complete and victims ideally should not wash, bathe, shower, eat, drink, brush their teeth or change their clothes before the examination commences.

In cases where there are suspicions of drug-facilitated sexual assault (DFSA) samples of urine and blood should be taken at the earliest opportunity due to the short detection times of substances which could be used to facilitate rape, such as gamma-hydroxybutyric acid (GHB).[19]

Forensic cut-off points for collection of DNA samples differ, depending on the body part involved. In oral penile penetration it is worth taking a mouth swab, mouth rinse or saliva sample for up to two days post-assault. In vaginal penile penetration with ejaculation, DNA evidence can be found in the endocervix for up to seven days post-assault, or up to three days in the ano-rectum. In addition, when looking for body fluids such as semen or saliva, skin swabs using a double-swab (wet and dry) technique can be utilized for up to two days after the material was deposited.[20]

Medical needs include dealing with injuries in the first instance, offering emergency contraception, and prophylaxis against and screening for STIs, including HIV, as well as facilitating a follow-up for screening for STIs, counselling and psychology. Many victims may need further referral to Social Services, Victim Support, a Community Safety Unit or other organizations which can offer them support after the assault.

One of the complex issues following rape is the issue of pregnancy. Not all clients decide to have a termination of pregnancy (TOP). Some are unsure what to do, particularly if they have been in a sexual relationship at the time.

In such circumstances *in utero* paternity testing using chorionic villus sampling and subsequent DNA testing can actually help the victim in the decision-making process. Those who opt for TOP can have products of conception used as evidence and those who decide to have the baby should be offered antenatal care.

NON-POLICE REFERRALS

Non-police referrals are a relatively new concept and involve gathering forensic evidence without police involvement. Sources of referral include complainants themselves, General Practitioners, Accident & Emergency Departments, genitourinary medicine clinics and other services. There are a number of choices to consider, including providing anonymous intelligence and/or samples for submission or long-term storage, as well as screening for STIs and psychosocial support. In addition it may be possible for the complainant to meet an independent SOIT-trained officer for a discussion without any obligation to report the assault.

MEDICAL WITNESSES IN COURT

One of the important duties associated with the role of Sexual Offences Examiner is providing additional support to the judicial system. Being cross-examined in court, particularly in the view of recent highly-publicized trials involving such expert witnesses, can be a daunting concept for a doctor. Over- and under-interpretation of findings may lead to wrongful convictions and may be borne out of ignorance, lack of impartiality, failure to recognize that there may be alternative explanations for the findings, or eagerness for the medical evidence to be granted greater importance then it deserves.

It is important for doctors to offer their assistance to courts through their opinions. Such opinions, however, should be objective, impartial, evidence-based and free from bias. A lack of good evidence-based research in cases of sexual assault highlights the fact that more needs to be done in this area to help physicians support their opinions in court.[21]

TRAINING AND ACCREDITATION FOR SEXUAL OFFENCES EXAMINERS

Becoming a Sexual Offences Examiner (SOE) is not a primary career choice for the majority of doctors. It is usually practiced alongside a principal career path in medicine, gynaecology or family planning. It is also not for everyone, as dealing with sexual assault can be very demanding emotionally and requires an ability to obtain evidential information and samples in the most sensitive manner. Good training is vital.

Training in the Havens was mentioned as an example of good practice in *Without Consent*.[14] It involves attending Adult and Acute Paediatric Sexual Assault Examination Courses, complemented by the Witness Skills Training Course, held several times a year and organized jointly by the Haven Clinical Staff and the Metropolitan Police.[22] This is followed by practical training consisting of shadowing three cases, doing three cases under supervision, review of forensic notes and witness statements as well as monthly peer review meetings.

Unfortunately, to date there has been no formal accreditation for SOEs in the UK. It is this writer's hope that future developments in the area of sexual assault will not overlook this important issue and that the newly set up Faculty of Forensic and Legal Medicine in the Royal College of Physicians will take it on board.[23]

CONCLUSION

An increase in reporting, low conviction rates associated with high attrition rates, public misconception and the lack of information about rape in general summarize the main issues in sexual assault at present. Added to it are: an association of rape with alcohol, the growing number of sexually assaulted adolescents and victims with mental health issues, many rapes happening within intimate relationships, and many assailants being known to the victims.

Multi-agency efforts have gone into improving services for those who have been sexually assaulted, starting from reforming the police, setting up SARCs and changing the way rape is prosecuted. Only time will tell if these efforts will make an impact on the conviction rates, the main outcome measure in rape cases. We should all hope that the improved levels of services and support offered when going through the process of investigation and trial will make the experience somewhat less traumatic.

Competing interests None declared.

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