

**TO REPORT OR
NOT TO REPORT:
A STUDY OF VICTIM/SURVIVORS
OF SEXUAL ASSAULT &
THEIR EXPERIENCE OF MAKING
AN INITIAL REPORT
TO THE POLICE**

Centre Against Sexual Assault (CASA House)
Royal Women's Hospital
Carlton Victoria



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CASA HOUSE

Kate Gilmore

Lise Pittman

assisted by

June Baker



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Elizabeth Chernov
Chairperson
Committee of Management
CASA House
1993

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INTRODUCTION

CASA House is one of thirteen sexual assault services that are in receipt of core funding from the Department of Health and Community Services. On the basis of a defined geographic catchment area, CASA House shares with these other services the responsibility of provision of support to those Victorians who have been subjected to sexual assault.

Key among CASA House's responsibilities is the provision of 24 hour, crisis care services to adult victims of sexual assault. Since commencing operation in May of 1987, CASA House has provided crisis services to an average of 200 victims of recent sexual assault per annum. In addition, each year some eight hundred survivors of *past* sexual assault seek support from CASA House.

This contact with victim/survivors of sexual assault provides CASA House with the benefit of exposure to a wide range of issues. It creates a unique opportunity to examine systematically the impact that sexual assault has on the lives of individual victim/survivors. However, it also places on CASA House the obligation to ensure the findings of such analyses are made public in such a way as to educate, inform and advocate in the interests of those who know only too well the facts of sexual assault: the victim/survivors of sexual assault.

For these reasons CASA House has initiated and made public the findings of a number of projects:

- 'Breaking the Silence' is a practical guide for health and welfare workers responding to victim/survivors of sexual assault;
- Through its 'Ethnicity and Sexual Assault' project, CASA House has researched strategies to enhance the cultural relevance of sexual assault services;
- A resource and training manual entitled 'Desperately Seeking Justice' provides a systematic examination of the issues related to violence against women in a culturally diverse community;
- 'A Pastoral Report to the Churches on Sexual Violence Against Women and Children of the Christian community' is a product of work initiated by CASA and undertaken with the support of different Christian denominations;
- 'Project Anna' is an education and training project aimed at assisting Christian churches to respond appropriately to violence against women.

This 'reporting to police' study is another of CASA's projects. Its impetus also comes from CASA's observations of the aggregate experience of victim/survivors of sexual assault; in this instance, as they encounter one of the key systems that has the formal mandate to provide a public and expert response to sexual violence.

The study's particular focus is on the response of Victoria's police to initial reports from recent victims of sexual assault. However, it is not intended to suggest, by the emphasis of this report, that the police are being, or should be, uniquely subjected to scrutiny. Also in progress is a tracking of victim/survivors' experiences of Victoria's Crimes Compensation system. And, in the spirit of 'fair play', CASA House has contracted an independent researcher to evaluate victim/survivors' experiences of CASA's own service provision system.

Nevertheless, the particular focus of this report reflects the weight that CASA gives to the 'to report or not to report' question. After all, it is the case that the criminal justice system and in particular, the police, play a powerful, authoritative role in the exercise of community response to sexual offences. Whether or not a woman chooses to report to the police, her decision will have a significant impact on her longer term recovery/survival. It is in the community's interest to ensure that the decision to report is one that a victim/survivor of sexual assault may take with confidence. Likewise, it is in the community's interest to ensure that the decision to *not* report is not based on a perception that the reporting system is traumatising, punitive and ultimately 'not worth the effort'.

This research commenced in 1991. Whilst there have been subsequent initiatives implemented by police to improve their response to recent victims of sexual assault, this research, to our knowledge, is the first of its kind because it makes visible the experience of the victims reporting the crime. The purpose of the research is to facilitate ongoing consideration of the range of issues that sit at the entry point to this formal reporting system. Further, it aims to identify additional possibilities for reforms that will enhance the quality of the response received by those against whom sexual assault has been perpetrated. An outcome that, in turn, will enhance the probability that those who perpetrate such crimes are brought to justice.

Lyn Walker
Coordinator
CASA House 1993

PUBLIC RESPONSES TO SEXUAL ASSAULT IN VICTORIA PRIOR TO 1993

The range of violent behaviours that constitute 'sexual assault' is a long standing feature of Australian society since the time of European settlement. However, in recent years and in particular during the time that this research was being conducted, community concern about sexual violence had grown and was met, in turn, by a more concerted government response to sexual violence. Now alongside 'family' or 'domestic' violence, sexual assault is recognised to be a pervasive and complex phenomena, that has a most devastating impact on the lives of women. For example, at the launch of Victoria's 1990 Women's Budget, the then Premier of Victoria, Mrs Joan Kirner, emphasised the seriousness with which violence against women is now viewed:

'I believe there is no more important issue than violence against women.' (Women's Budget Launch, 1990).

If government activity is taken as a measure of increased public awareness of and concern about sexual assault and other forms of violence against women then there are a number of indicators of the dimensions of that concern.

2.1 THE VICTORIAN GOVERNMENT'S ACTIVITY ON ISSUES RELATED TO VIOLENCE PRIOR TO 1993

The past Premier's concern was reflected in the spread of related government activity. For example:

- The Department of the Premier and Cabinet auspiced a number of bodies that had the mandate to provide advice on areas of direct relevance to violence including sexual assault: for example, the Public Safety and Anti-Crime Council, the Victorian Community Council Against Violence (VCCAV) and the Victorian Advisory Committee on Rape (VACOR).
- The Attorney-General's Department auspiced the Family Violence Prevention Committee, of which there was a number of issue specific taskforces that drew in the participation of the Ministry of Housing and Construction, the Ministry of Education and the Health Department Victoria.
- The Health Department Victoria (HDV) developed policy and provided resources to

establish sexual assault services in each of the Health Department regions.

- Community Services Victoria (CSV) had a significant role through its child protection services and its family support functions. More specifically it funded both the Victorian Women's Refuge Program, which provides emergency accommodation services to women and children who are escaping domestic violence, and information and support services such as the Domestic Violence Outreach Program and the Domestic Violence and Incest Resource Centre.
- The Ministry of Education played a role in increasing the opportunities in secondary and tertiary curricula to educate students on issues related to violence against women. Two clear examples of this role were the *Standing Strong* education package and the work of the Professional Education Taskforce of the Family Violence Prevention Committee.
- The Ministry of Transport responded to the issue of safety on public transport by establishing the Safe Travel Forum and took measures to reduce the level of violence within the Taxi industry.
- The Ministry of Police and Emergency Services (MOPES) funded a media campaign to shift community, in particular men's, attitudes that contribute to violence against women and, through the Good Neighbourhood Program, funded the West End Forum to respond to the issue of violence in and around Melbourne's west end licensed premises. MOPES also provides funding for the Protective Behaviours Programme focusing on family violence and sexual assault issues.
- The Office of the Public Advocate considered in some depth the problem of violence against older people through its 'elder abuse' study and its research on intellectually disabled people as victims of crime.

2.2 THE RESPONSE OF THE CRIMINAL JUSTICE SYSTEM

A key area of concern and subsequent increased government and non-government activity was the criminal justice system and its investigation and prosecution of violent crimes, such as sexual

assaults. This concern was reflected in work undertaken with Victoria Police and by the recently disbanded Law Reform Commission of Victoria.

Victoria Police developed, for example, the Victim Liaison Office and the Family Violence Project Office which oversees training for police members on family violence matters such as the intervention orders provided by the Crimes (Family Violence) Act. The Victoria Police Crisis Support Unit was also established after recommendations made by the Melbourne Crisis Care Association. Consequently, the Crisis Support Unit responds to family violence incidents which require crisis intervention and is staffed by counsellors and police officers.

In regard to sexual offences, Victoria Police implemented a specialist training course that includes an emphasis on 'victim sensitivity' when a sexual offence complaint is made. And a specialist investigation team, the Rape Investigation Squad, joined with the Community Policing Squad and the Child Exploitation Unit in bearing principal responsibility for police response to sexual offences.

The Law Reform Commission of Victoria, over some years, reviewed the legal system's response to sexual assaults. It provided State Parliament with reports on procedural and substantive aspects of sexual offences legislation and on the particular issues associated with sexual assault of children and of the 'mentally impaired'.

More recently the Commission, in conjunction with key groups such as the Real Rape Law Coalition, was engaged in work both on the definition of rape, including definitions of consent, and on the surrounding system issues. An important outcome has been the reforms secured through the Crimes (Rape) Act, 1991.

2.3 INITIAL POLICE RESPONSE TO SEXUAL ASSAULT REPORTS

The Law Reform Commission also considered a number of aspects of the role of the police in the provision of a public response to sexual offences. Most relevant to this discussion was the Commission's attention to the quality of the initial response that police provide to those who are lodging a sexual offences complaint.

(NB: CASA House's research commenced some time prior to the Commission's consideration of this question. When it became clear that this was a shared interest, the preliminary findings of the Centre's research on initial police response were made available to the Commission.)

An important outcome of the Commission's consideration of initial police response was the formation of a working party of representatives from Victoria Police and the Centres Against Sexual Assault. The Victoria police developed a code of practice for the police when responding to victims of recent sexual assault. The code of practice was further refined and developed by the working party, resulting in the formation of procedures.

This Code anticipates many of the concerns that arise from CASA House's research into police responses. Its main objectives are:

- To provide for a co-ordinated approach in the handling of sexual assault cases by the police, sexual assault centres and other victim assistance programs.
- To increase the confidence of sexual assault victims and the public in the police handling of sexual assault cases with a view to increasing the proportion of sexual offences reported.
- To increase the likelihood of offenders being caught.
- To maximise the number of successful prosecutions.
- To minimise the trauma experienced by sexual assault victims throughout the investigative process.

(Police Instructions for Sexual Assault Cases, LRCV, 1991c)

At the same time, the Victorian Community Council Against Violence, in examining its reference on 'violence in public places', undertook a significant research project that profiles rapes reported to Victoria Police in the years 1987 to 1990.

The Council's research was based on data retrieved from official police documents such as Victim Statements, Crime Reports and Sexual Offence Reports. Through statistical analysis of the information that the police document about victims of rape, the VCCAV provides important insight into

the circumstances in which rape (that is *police-reported* rape) occurs.

Significantly, the VCCAV report provides further evidence that reveals as inaccurate, the stereotypes held regarding who is raped, who rapes and under what circumstances rape occurs (VCCAV, 1991:76pp).

Of the issues pertaining to police reporting the Community Council observes:

The victim herself has to undergo a gruelling process of reporting, description, medical examination, and verification procedures in the initial stages of an investigation . . .

The discretionary power of an individual officer who receives the original report means that inevitably there will be some inconsistency in acceptance of the report and in treatment of the victim. (1991:75)

In conclusion, the VCCAV:

. . . emphasises strongly . . . the need for a further study which focuses on victims. This would provide a necessary balance to information already utilised. (1991:75)

CASA House presents its study into initial police response to victim/survivors' reports of sexual assault, as a contribution towards the achievement of this needed balance. We do so while recognising that, to the best of our knowledge, this is the first study of this kind in which the emphasis is placed on the victim/survivors' own experience of the processes involved in lodging a formal report with

the police. It is our hope that this will be the first of many such studies.

2.4 SUMMARY OF RECENT PUBLIC RESPONSES TO SEXUAL ASSAULT IN VICTORIA PRIOR TO 1993

Taken as evidence of the growth of public concern about violence, related government activity up until 1993 demonstrates an unprecedented level of public commitment to establishing an appropriate response to those who are subjected to violence and to meeting the challenge issued by the goal of the elimination of violence.

Recent work undertaken by both the Victorian Community Council Against Violence and the then Law Reform Commission of Victoria provides a measure of this level of public concern as it relates to the criminal justice system's response to sexual violence. The nature of the arguments and issues considered by both the Council and the Commission suggest the public perception is that the criminal justice system could benefit from additional reforms of the kind that would enhance the quality of its response to victim/survivors of sexual assault.

While CASA's research was initiated prior to that of the Community Council's and the Commission's, it is hoped that its unique and particular focus on the experiences of victim/survivors will complement both the Council's findings and the relevant work carried out by the Law Reform Commission of Victoria.

TO REPORT OR NOT TO REPORT: THAT IS HER DECISION

PREVIOUS RESEARCH

3.1 INTRODUCTION

The public concern with violence against women and the relevant activity of the State government have highlighted a number of issues. Among these is one which is central to this call for a more public and serious response to sexual assault: the securing of formal justice for the victim and formal condemnation of the offender. The sole formal avenue through which to achieve these two aims is the criminal justice system. This means that the role played by legal officialdom including its police officers, is of pivotal importance.

For the victim/survivor, it is the police who are the point of first contact with this system. In their gate keeping role, the police have the responsibility and the authority to screen all reports of sexual assault.

While an official police report is the point of entry into the system that is mandated to distribute formal redress, this *just redress* is not the only purpose for which such a report is necessary. A police report is a prerequisite if the victim/survivor is to gain access to a range of entitlements that are designed to assist her to manage the consequences of a sexual assault. These entitlements include priority access to emergency and/or longer term housing; support for a Workcare application; a successful application for modification of immigration status or for crimes compensation.

Thus, the decision as to whether or not to report to the police brings with it a range of implications. For the victim of sexual assault, one of the most pressing decisions that she must face is to either approach or turn away from this entry point into the system of legal redress.

The onus then, is on the criminal justice system to ensure that the dynamics which facilitate access to formal justice and those which inhibit it, are well understood. At the entry point, these influences turn on the role of the police.

The literature suggests that many variables may affect the victim/survivor's experience as she lodges a report with the police but identifies the response of the police as being among the most potent:

3.2 THE INCIDENCE OF SEXUAL ASSAULT

In the first instance, no one knows how many women must grapple with the decision as to

whether or not to report to the police. While more recently there has been a wider acknowledgment that violence against women is a large scale problem, its actual incidence can only be *guess-estimated*. As was noted by Townsend and Stewart on data relating to the incidence of violence against women:

All estimates are underestimates. (Country Report, 1990: 8).

The reasons for this dearth of accurate information on the extent and incidence, in particular, of sexual assault are many, varied and complex. In part, it is a reflection of the absence of systematic and rigorous research. In part, it reflects the technical difficulties associated with achieving epidemiological measures of social phenomena; particularly where a phenomenon, as is the case in regard to sexual assault, is steeped in popular mythology as to its definition and its etiology.

Nevertheless, there are a number of estimates that have been accepted as indicators of the extent to which sexual assault is a feature of contemporary, western societies:

One out of ten women will be raped in their life time. (Offir, 1975; Haines, 1985)

Thirty-eight percent of girls and nine percent of boys will be sexually assaulted in some way by the time they are 18 years of age. (Finkelhor, 1979; Russel, 1983; Goldman, 1986)

In one out of ten homes incest is taking place. (National Coalition Against Sexual Assault Conference Papers, 1987)

Rape occurs within approximately seven percent to twelve percent of all marriages. (Finkelhor & Yllo, 1985; Russel, 1982)

Seventy-six percent of female and seventy percent of male child sexual assault victims know the offender. (Finkelhor, 1979)

In the overwhelming majority of instances of child sexual assault, the perpetrator is the father, step father, mother's de facto partner or grandfather of the victim. (Finkelhor, 1979)

Approximately one out of ten sexual assault victims report the assault to the police. (Klimkiewicz et al, 1984; Haines, 1985)

Even if these figures were treated with scepticism to the extent that they were read as over estimating the incidence of sexual assault by a factor of two or as much as four, when compared with official crime statistics they point to an overwhelming rate of non-reporting to police.

Thus the literature predicts that those who do report to the police are among the minority of victim/survivors and thus, by definition, are likely to constitute a biased sample of the total population of women who are subjected to sexual assault.

3.3 THE INCIDENCE OF REPORTS TO THE POLICE

The data provided through the social sciences, including population based research, remain relatively scant and on the basis of perceived methodological weaknesses, are subjected to a degree of criticism.

Police statistics, on the other hand, have received greater acceptance as one means by which to secure a measure of the incidence of sexual assault; clearly they provide a measure of how many sexual assaults are reported to the police.

The Victorian Community Council Against Violence reviewed police records of 1437 rapes reported from 1987 to 1990. In preparation for that study the Council established that:

in 1980 some 320 rapes were reported but by 1990/91 some 590 reports were received.
(VCCAV, 1991:4)

This rate of increase over the past decade cannot be said to indicate an increase in the incidence of sexual assaults; it is safer to say that with growing public awareness of the serious nature of this crime and with the added availability of support services, more victims are making the choice to report to the police.

However, methodological flaws notwithstanding (National Committee on Violence (NCV), 1990: 6-14), a significant limitation of police statistics as an 'extent and incidence' measure, is that they count only those assaults that are the subject of a formal report to the police. While this data, when collated and analysed, can tell us about the nature and incidence of sexual offences reports *as recorded by police*, they cannot inform us about the majority of sexual assaults: those that do not reach the point of a police report.

3.4 THE INCIDENCE OF NON-REPORTING TO POLICE

The fact is that sexual assault is a most under-reported crime (NCV, 1990:6). It is estimated that only *one in every ten* of sexual offences committed in Australia is reported to the police (Summers, 1975; the Police Complaints Authority of Victoria (PCA), 1988; CASA House, 1990:4). For example, while social research estimates that rape occurs in as many as twelve percent of marriages (Finkelhor & Yllo, 1985), in 1990/91 only eight reports of rape in marriage were received by the police and of these, only two were proceeded against (VCCAV:3).

Given that the vast majority of sexual offences are hidden from the criminal justice system, a key question must be: Why is it that the majority of sexual offences are not reported to the police?

3.5 THE DECISION NOT TO REPORT

In seeking answers to this conundrum, the literature identifies a variety of factors that act either as *disincentives* to reporting or as *incentives* to not report:

• A Problem of Timing

The decision as to whether or not to report a sexual assault to the police is taken by the victim/survivor most often at a time when the impact of the assault is at its most immediate and intense: at the point of significant crisis. Therefore, to understand the nature of this reporting decision and the context in which it occurs, the immediate and longer term impact that sexual assault has on a woman's life must be considered.

As numerous authors have emphasised sexual assault creates for the victim massive and potentially long-lasting trauma (Arbarbanel, 1976; Toner, 1977; McCombie, 1980; Sullivan, 1986; Kelly, 1988; Gilmore, 1989).

Its immediate physical impact may include severe physical injury but also will bring the threat of unwanted pregnancy and sexually transmitted diseases.

Its emotional impact will be long-lasting. The immediate emotional consequences of sexual assault often include: terror, anguish, disgust, an overwhelming sense of personal vulnerability, shock, perhaps numbness or denial. The victim

may even experience euphoria: having believed that she could be killed, the attack is over and she has survived (CASA House, 1990).

But, in the proceeding days, weeks and months she will experience this emotional impact in a wide range of forms such as disturbed sleep, frequent nightmares, flashbacks to the attack, embarrassment, perhaps shame; eroded self-esteem, depression, anxiety, hostility, anger, loss of sexual confidence, a sense of being trapped or a sense of isolation. She may experience erratic mood changes; if she has internalised the mythology about who is responsible for sexual assault, she may experience debilitating guilt (CASA, 1990: 37-50).

The impact of the assault will flow into her relationships with others. For example, if she was assaulted by someone known to her then her assumptions about whom she can trust are shattered. If the assailant is a stranger, the victim will be left with an overwhelming sense of life's unpredictability and inherent dangers. Her close relationships, such as those with her family and/or her partner will be placed under considerable pressure, as she is forced to manage not only her own grief but that of everyone around her.

She may encounter a range of financial difficulties as she attempts to manage the consequences of the attack and takes measures that she believes will ward off any possibility of further assaults. For example, if she has been assaulted at work and/or by a work colleague, she must resolve a significant employment crisis. If she has been assaulted in her own home and/or by her partner, she has no option but to manage a severe housing crisis. In any event, there is a strong likelihood that there will be significant financial ramifications to be managed.

The fact that victim/survivors of sexual assault are over-represented among those women who are managing a drug dependence, eating disorders and/or chronic depression, provides an indicator of the longer term consequences of sexual assault (CASA, 1990:36).

The circumstances in which she was assaulted: the location of the assault, the identity of the offender and the nature of the attack, will have a potent influence on the extent to which the assault impacts on a woman's life. However, it is also the

case that her management of these consequences will be influenced dramatically by a range of other factors: by her emotional, economic and social resources; by the manner in which family and friends respond to her and, importantly, by the treatment she receives from those whose official responsibility is to respond to reports of sexual assault.

• A Problem of Definitions

An additional influence working against the lodging of reports with the police, is the complex issue that serves to muddy common judgement as to whether or not in a particular situation a particular experience at the hands of a particular person, constitutes a sexual offence.

The history behind the *criminalisation* of rape in marriage provides perhaps the most glaring example of the fact that, for the victim, the judgement as to the degree to which the assault, in a formal sense, is criminal is not (necessarily) straightforward. For example, until 1985, (under English law, until 1991) Victoria's legislated and common law position in regard to the criminality of rape in marriage was ambiguous. It left available to the defence case, the option of arguing immunity from a charge of rape on the grounds that the accused at the time of the alleged rape, was married to and living with the victim.

The ramifications of this anomaly resound. If the law could not define as criminal the literal act of rape where it was committed by a husband against his wife, then the police could not accept a formal report of rape where it had occurred under such circumstances. If the police could not accept such a report, rapes in marriage could not be counted in the crime statistics. If rape in marriage did not count then no community member was in a position to choose to report such assaults. Ergo, such assaults were not reported.

The principles of natural justice applied to human relationships make sexual assaults (even in marriage!) naturally unjust. However, natural justice does not produce, in a pure and direct sense, the letter of the law, its interpretation or its implementation. More often these elements of the legal system are a product of the particular historical and social moment in which they exist.

This *social construction* of criminal behaviour has provided ambiguous and conflicting messages

as to the criminality of sexual assault. Such a tradition cannot and has not provided a firm basis from which a woman can make with confidence the decision that she has grounds on which to lodge a formal report (Box, 1983).

Further, the victim's own experience of the seriousness of the sexual assault, and of the severity of its impact, will not necessarily correspond with legal notions and definitions about what constitutes a serious assault. For a range of reasons, she may underestimate the criminality of the assault. Alternatively, the legal system may not regard her experience as criminal. Nevertheless:

It must be remembered that sexual assault exists on a continuum and that all forms from harassment to violation are experienced as threatening and can have devastating consequences for the victims/survivors. (CASA, 1990:46)

• A Problem of Repercussions

The victim must also consider that a report to the police may place in danger her life and that of those to whom she is close. Particularly if the offender is known to her and/or knows where she lives or works, she will be faced with the fear that once he discovers that a report has been made he may seek to find her and subject her to further violence. This is a fear made even more realistic given that the criminal justice system is frequently unable to protect its witnesses (Kelly and Radford, 1987:245).

Again, if the offender is known to her, the victim/survivor may fear that her friends and family will be divided as to whom to believe and whom to support: the victim or the offender. The potential that such a division holds for causing her social and emotional isolation creates a significant disincentive to reporting.

• A Problem of Secondary Victimisation

Furthermore, when determining whether or not to report, the victim of sexual assault must also consider the experience that she will have within the legal system. She must deal with a commonly held fear of the potential harm inflicted by the system itself and by its agents; in particular she must assess her strength to manage the fear that she will encounter scepticism from the police (RRLC, 1991:17-18; Hatty & Scutt, 1987). Her own

family, partner or friends may actively discourage reporting for reasons similar to those that deter the victim: believing that the lengthy process of investigation and subsequent court hearings will exacerbate the damage and delay recovery.

It is well established that reporting sexual assault, not to mention proceeding to trial, is, in and of itself, a traumatic experience (Williams, 1981:32; PCA, 1988:61). As a former Victorian Chief Police Surgeon, Dr P. Bush emphasised, doctors, the police, the law, the media and the larger community can compound the trauma of sexual assault through ignorance and consequent inappropriate response (Bush cited in Kille, 1986).

Thus, a sexual assault victim can be said to experience not only the actual sexual assault. Rather, she faces the prospect of further assaults as she encounters the reactions of others including, if the incident is reported, those of the agents of the criminal justice system (Real Rape Law Coalition [RRLC], 1991:21; Law Reform Commission of Victoria [LRCV], 1991b:148).

The police, as the gate-keepers of this system, are first among those whose role brings the potential to re-victimise. If they are unable or unwilling to provide the appropriate empathy and support, they may compound the victim's trauma thus hindering or discouraging the further pursuit of legal action. The public reputation that is earned by such behaviour may also deter other victims from approaching the system (LRCV, 1991a:17; PCA, 1988:17).

The very personal nature of the crime, the intimate and sexual explicitness of its detail, means the process of step by step description of the assault is, for the victim, invariably harrowing. The prospect of relaying such detail to anyone is daunting; how much more so when such detail must be relayed to uniformed and armed strangers as is the case when making a statement of formal complaint, to the police. By virtue of their entry point function, these hitherto strangers have the power to decide whether or not to proceed with legal action. This is the power to formally invalidate the victim's experience or to refer it to the courts in which reside the sole power to formally validate the woman's perception (and indeed her lived experience) that she has been the victim of a heinous crime.

• A Problem of Stereotypes

The failure to report in some instances may be linked to the set of (false) stereotypes that are held about who rapes, who is raped and in what settings rape occurs (Carmody, 1984). The literature suggests that a woman's reluctance to report a sexual offence is correlated to the extent that there is a match perceived between these stereotypes and the actual circumstances of the attack perpetrated against her (Shapcott, 1987). The extent to which she, her friends or family, or the police to whom she must consider reporting, uphold or are perceived to uphold these stereotypes will directly influence the reporting decision and its subsequent reception.

The degree to which a crime is considered 'serious' may provide a potent influence on the reporting decision. For example, there have been published media statements in which police and other officials are quoted as having expressed priority concern with 'serious' rapes (read: 'stranger' rapes), implying the existence of another set of rapes that are judged to be 'not serious'. Such reports leave the public with a perception that the police and other officials will consider less serious any report of a sexual offence that does not conform to this stereotype. These assumptions about the nature of 'real crime' have been observed by Hogg and Findlay who suggest that:

Police images of 'real' crime and disorder still tend to be organised around stranger-to-stranger conduct committed in public or involving violations of property. (1988:51)

However, the facts are that the majority of sexual offences are committed, not by 'psychopathic' strangers in 'dark, back lanes' (i.e. 'serious') but by otherwise 'respectable' men in familiar social and domestic settings against women with whom they have a 'trusting' relationship (Groth, 1979; Bonney, 1985).

Thus, the majority of victims will be in a position where they may perceive that the assault to which they were subjected was not a (stereotypically) 'serious' crime or where they may anticipate that they will not be received by the police as befits a victim of a 'serious' crime; a perception that may well be a realistic assessment.

The literature also points to an inherent 'class' bias in crime statistics. For example, it is asserted with

regard to a range of criminal behaviours, that members of the middle to upper socioeconomic classes are firstly less likely to be reported for the crimes that they commit and secondly, for reasons related to status, are more reluctant to report crimes against them where the nature of that crime is perceived to threaten or tarnish their public standing (Scutt, 1980: 537). If 'middle to upper class' or 'white collar' crime is under-reported, it is also 'under-counted' in the crime data, contributing to the stereotype concerning, for example, the socioeconomic class of the rapist and of the raped.

With regard to sexual assault, this stereotype may have a particular influence in circumstances where the offender is also a family member or is a man of otherwise high public standing, for example, a member of the clergy or a senior executive (Shapcott, 1987:85).

It is clear that the 'stereotyping' factor has the potential to play a significant role in the decision taken by the majority of victims to leave offences unreported. It is also possible that this factor may mean that some offences are dismissed by the police prior to formal acceptance of such a report (Box, 1983).

• A Problem of Police Attitudes

No large organisation that employs a staff of many thousands to carry out a myriad of complex tasks is able to ensure that each person, on every occasion, will adopt the attitudes and behaviours that are necessary to provide an optimal service. Victoria Police cannot be criticised for these complexities which it shares with other large organisations:

Police forces generally are getting bigger and bigger, and if there is any natural law of organisation, it is the one which ties size to the formality and complexity of organisational structure. (Bradley, 1988:177)

However, the 'entry point' function that is played by the police is of such importance that a concerted effort is warranted to minimise unnecessary diversity in the police response and to maximise the quality of this response.

On this basis, the police response to victims of sexual assault has been subjected, over time, to specific criticism. It is acknowledged that the

various sections of the police force differ in their response to sexual assault victim/survivors, as do individuals within each section. On the one hand, as this study will demonstrate, many victim/survivors are satisfied with the treatment that they have received from the police and, in particular, from the Community Policing Squad. However, sections such as the Criminal Investigation Branch frequently elicit an expression of strong dissatisfaction from victim/survivors (RRLC, 1991:39; LRCV, 1991a:17).

Clearly, positive attitudes are not the problem. Rather, the issue is that adherence to stereotyped views and myths about sexual assault in particular, and about male violence against women in general, appears to be prevalent among police officers (PCA, 1988:17; Hatty, 1988:48,183; Hatty & Scutt, 1987; Bureau of Crime Statistics & Research, 1985:17). For example,

... the attitudes of some members of the Victoria Police in relation to sexual assault victims remains sexist, stereotyped and judgmental. (PCA, 1988:17)

While further traumatising victims, these stereotypical notions may also lead police to screen out, prematurely and inappropriately, numerous cases, especially those in which consent is a major issue (LRCV, 1991a:6). The Law Reform Commission emphasises that:

Men should not be able to escape conviction simply because they hold inappropriate and outdated notions about seduction, sexual conquest and female sexuality. (LRCV, 1991a:11)

Similarly, these are not notions that police members, by their own attitudes or behaviours, should reinforce. Nevertheless, numerous sexual assault victim/survivors are made to feel that from the moment they report to the police they are placed on trial (Allen, 1990:9; SRCC, 1990:44):

It is not for the police to make a determination as to the guilt of any person, yet the police response to complaints of criminal assault at home, like that to complaints of rape, is generally weighted unfavourably against the victim. (Scutt, 1988:31)

Sexual assault victim/survivors have complained that the police have been unsympathetic and unsupportive; have made unfounded value judgments that attribute responsibility for the assault

to the victim; have asked inappropriate and irrelevant questions; and have made the victim feel uncomfortable, devalued, guilty or blamed (RRLC, 1991:29; Hatty, 1988:72). For example, the Sydney Rape Crisis Centre, suggesting that inappropriate questions are common, believes it is necessary to advise women that:

Police officers should not ask questions such as, 'did you enjoy it?' or 'did you climax?' (SRCC, 1990:46)

The danger is that attitudes and values which are based on prejudice and misunderstanding can deny or trivialise the harm which is wrought through sexual assault, can diminish the perpetrator's responsibility for the violence to the extent of blaming the victim, and can unduly question the victim's credibility (CASA, 1990:13-20; Hatty, 1988:69-73,85; Burt, 1980; Shapcott, 1988; SRCC, 1990:17-20).

• A Problem of 'False' Reports

A number of authors have noted that the popular and yet inaccurate perception that women frequently (falsely) 'cry rape' appears to be shared by a number of police (LRCV, 1991a:17; RRLC, 1991:29; Hatty & Scutt, 1987). The Police Complaints Authority of Victoria reported that:

We have been told of widespread misunderstanding of the reactions of such victims, ... of routine scepticism in face of distressed rape victims ... and of preparedness to cross-examine victims as though they were suspected of serious crime. (PCA, 1988:2)

Scutt has suggested that:

It is notorious that the rate at which complaints of rape are held or designated 'unfounded' by police is inordinately high — and that, in jurisdictions where rigorous testing has been carried out of 'unfounding', the real rate is no higher than the rate of false complaints in other crimes. (1988:33)

For example, a member of the Special Projects Section of the South Australian Police Department, having conducted a study of rapes reported over a four year period to South Australia's police force, concludes that:

very few (only 1.4%) of the reported rapes are actually false reports, that is, (in very few instances) the offence is not substantiated. (Weekley, 1986:44)

Conversely, almost one-third (28%) of all rape offences reported to the Victoria Police between 1987-1990 were judged by the police to be 'false reports' (Victorian Community Council Against Violence [VCCAV], 1991:20). Even this figure is most likely an underestimation of the number of reports considered false by Victoria's police given that:

There has been significant dissatisfaction with the adversarial practices of police who regard it as proper practice to 'cross-examine' victims to determine the validity of their complaint before recording the complaint at all. (PCA, 1988:56, emphasis added)

This also tends to support the assertion that members of the Force often 'act too much like judge and jury' (LRCV, 1991b:124).

Responding to the problem of premature and perhaps poor judgement that significant numbers of reports are 'false', the Law Reform Commission has recommended that the police be required to provide a written explanation for any decision not to proceed with further action; and that the victim/survivor be provided a formal right of appeal to the Department of Public Prosecutions (LRCV, 1991a:52; Victoria Police Code of Practice, 1992).

• A Problem of Complex and Competing Needs

A common source of concern is the perceived failure of the police to strike a consistent and compassionate balance between the victim/survivors' needs and the demands of investigative and administrative priorities (LRCV, 1991a:17).

The practice of immediately obtaining statements from sexual assault victims, often despite the victims' protestations, while they are still in shock, perhaps prior to receipt of medical care or the provision of rest, constitutes a further form of re-victimisation (RRLC, 1991:40; LRCV, 1991a:23).

And yet, such a practice actually increases the risk that significant details will be omitted from the victim's statement which may, in turn, affect the victim's credibility with devastating consequences

for the prosecution should the case proceed to trial (LRCV, 1991a:23).

To the inexperienced or sceptical officer, a state of shock can too easily be misinterpreted as fabrication (CASA, 1990:45). The PCA reported that:

For a person in shock to be subjected to persistent questioning by a series of authority figures whom she does not know and whose roles she does not understand is both cruel and absurd. (1988:44)

The Law Reform Commission has advised that attention should be paid to the fact that a victim may have been in need of rest even before the assault took place, not to mention as a consequence of the effects of the attack itself. The Commission recommends that if the victim is unable to give an immediately detailed or accurate statement, then the statement should be deferred (1991b:25; Victoria Police Code of Practice, 1992).

• A Problem of the Demands of the Police Statement

There are a number of issues associated with the taking of this initial statement. The current method involves a tedious process of manually recording victims' statements; a process which frequently can take up to eight hours to complete and has been known to extend into the succeeding days. If this statement is taken too early in the reporting process, it can mean the passage of several hours before the victim has a medical examination, the opportunity to wash and rest, or a chance to seek support from family or friends (LRCV, 1991b:23; PCA, 1988:2; Victoria Police Code of Practice, 1992).

If the statement is taken immediately after the examination, the issues of shock and the need to rest are still present.

As one step towards resolving this matter, the Law Reform Commission has suggested that tape-recorded statements be considered. This may be an economic, efficient and humane alternative that minimises the trauma to which the victim is subjected and yet meets the demands of police investigation (LRCV, 1991a:24).

• A Problem of Cooperation with Other Services

Some concern has been expressed regarding the failure of the police to refer sexual assault victims

to sexual assault centres. It appears that the police are most likely to refer victims to a Sexual Assault Centre if the police accept/believe the sexual assault report (Bureau of Crime Statistics & Research, 1985:9). However, it also appears that, particularly if the alleged assault is an attempted rape or an indecent assault rather than an 'actual' rape, the police assume no referral is necessary. This suggests a level of ignorance about the impact of sexual assaults irrespective of whether or not actual penetration occurred, and about the role of support services.

However, the fact is that personalised support such as counselling is an important tool by which victim/survivors can be supported in the process of surviving both the immediate and longer term consequences of sexual assault (LRCV, 1991b:131). Even in the event of a police judgement that a report is 'false' the need for counselling as an option for the complainant should be obvious:

It is important that a victim of sexual assault be placed in a position to take back control of her actions, a control which the violation of her person has deprived her of, as soon as possible. Decisions should not be made for her. Options should be presented. This is one of the reasons why the involvement of a counsellor before a woman is pressured to make a statement to police or to undergo a forensic medical examination is so important. (PCA, 1988:44)

It has also been noted that police do not always give sexual assault services or their host hospitals adequate notification of their intention to bring the victim to the Sexual Assault Crisis Care Unit. This lack of early warning delays arrival of the Counsellor/Advocate and of the police surgeon/forensic medical officer whose absence then further prolongs the victim's discomfort (PCA, 1988:48).

In fact, the term 'discomfort' is too mild to describe the experience of the sexual assault victim/survivor. Until the completion of the forensic examination, which is essential to the securing of corroborative evidence, the victim ought not wash herself in any way or change clothes or go to the toilet or eat or drink anything. In other words to meet the stringent evidence requirements, the victim is obliged to remain in the state in which she was left by her attacker. Any avoidable delay in providing her with this forensic examination is

an avoidable delay in providing her the option to cleanse and nourish herself. Such delays are self evidently inhumane.

In addition to the forensic implications of unnecessary delay, a delay in the provision of medical attention may have serious consequences for the victim/survivor's health including the threat of unwanted pregnancy and sexually transmitted diseases (LRCV, 1991b:122; CASA, 1990:25).

• A Problem of Support and Information

The sexual assault victim/survivor's autonomy has been violated; a feeling that will persist well beyond the actual attack. In order for the healing process to begin, it is important that the victim be offered maximum control over the decisions that affect her. To make informed decisions, the victim/survivor must be given accurate and detailed information regarding, in particular, the options that are available to her (PCA, 1988:44; CASA, 1990:29; LRCV, 1991b:123).

Police arrangements for providing information and follow-up services to victim/survivors are 'somewhat ad hoc and quite often break down' (LRCV, 1991b:124). Sexual assault victims already have experienced an ultimate powerlessness. Where the police fail to provide adequate information to the victim/survivors they become complicit in the perpetuation of this sense of powerlessness (LRCV, 1991a:25).

To guard against the possibility that the victim is not informed as to her options the Police Complaints Authority recommended that a joint police — sexual assault services protocol be developed to protect the victim's right of access to a counsellor prior to the medical/forensic examination and the statement-taking procedure (1988:74). The Law Reform Commission reiterated this recommendation and subsequently oversaw the establishment of a code of practice to guide the operations of police members and to support cooperation between the police and the other relevant services (Victoria Police Code of Practice, 1992).

• A Problem of Police Training

According to the Police Complaints Authority, as recently as 1988:

... the training of police recruits and even those primarily responsible for dealing with sexual assaults is primitive in the extreme and thoroughly inadequate. (1988:2).

The Law Reform Commission reiterated this concern in relation to members of the Criminal Investigation Branch who often have extensive contact with victims during the investigation stage:

(The CIB) receive little or no formal training on matters relating specifically to victims and their welfare. (1991a:22)

A consequence of unskilled or insensitive response from police members is that, despite exercising the considerable courage it requires to make an initial report, some victims refuse to proceed with further legal action once they have encountered the problems associated with the police response (Whitrod, 1986:77-78).

It would be unreasonable to expect of Force members detailed and specific expertise in the myriad issues associated with the long term support of those who have been subjected to sexual assault. This is not their role and it is a key reason for the provision of specialist support services such as Centres Against Sexual Assault. Nevertheless, it must be recognised that the victim's cooperation is essential to the pursuit of prosecution. The securing of this cooperation does require the police to have specific skills in crisis management and specific knowledge of the fears and concerns that are common to all victims of recent sexual assault.

• A Problem of Lack of Confidence in the Legal System

A number of researchers have pointed to the public crisis of confidence in the legal system, particularly in regard to the system's management of sexual assault (LRCV, 1991a:15). This public lack of confidence has its individual expression in both a woman's reluctance to 'run the risk' involved in making a report and in police reluctance to investigate reports when they do not foresee a successful prosecution (Connors, 1988:23).

As Justice Vincent has noted, this lack of confidence is a product of a combination of factors: the treatment the victim receives at the hands of police, the demands of the forensic examination, the experience of the investigation, the committal

hearing and trial cross examinations and the perceived pattern of disappointing trial outcomes, including inadequate sentences (Vincent: Speech at the launch of the VCCAV report on police-reported rape, 1991).

This crisis of confidence is not merely academic. The fact is that many sexual assault victims regret having reported the assault to the police; many also indicate that they would be reluctant to report again if subjected to another sexual assault (LRCV, 1991b:120,149).

3.6 SUMMARY OF PREVIOUS RESEARCH

Undoubtedly there is an increase in public concern about violence against women and in particular, about the hidden incidence of sexual assault and the need to increase the rate of apprehension of assailants. The legal system is the only formal means by which such apprehensions can occur, the sole means of redress open to victim/survivors of sexual assault (LRCV, 1991b:148) and for the victim, it is an important point of access to other entitlements. Therefore, an essential and primary aim must be to minimise the trauma experienced by the victim/survivor who chooses both to exercise her legal rights and to concur with community expectation, by seeking the prosecution of the rapist.

Research has already shown that there is some concern regarding the legal system's response to sexual assault victims and more specifically, regarding the police response in their role as the gate keepers of that system. It is important to acknowledge:

In the context of violence against women and children . . . the police role is ambiguous and the task difficult. Certainly, the police response (to sexual assault) is not enhanced by the attitude of the legal system and the wider society which combines to trivialise abuse of women and children, removing it from the purview of the criminal system and relegating it to the rag bag of social problems. (Connors, 1988:23)

However, as the National Committee on Violence Against Women emphasises, sexual assault is a crime (1991:11) and thus, by definition, demands a competent, just and fair response from the legal

system and its officials. Writing in regard to the police role, Connors reminds us that:

. . . it cannot be overemphasised that the best evidence, which is essential to successful prosecution, can only be gleaned from the best treated complainant (i.e. the victim). Intelligent and enlightened treatment of the complainant from the human perspective thus becomes the critical key in the success of the police function of law enforcement. (1988:24)

The transformation from victim to survivor requires courage and endurance. It is in the community's interest to enhance rather than hinder, this process of transformation. It is also in the community's interest to deal with the offenders; an improbable task without the victims' cooperation. Priority must be given to strategies that identify and minimise, if not eradicate, any current or potential factors that work against the victim's exercise of her legal right to report a sexual assault to the police or that cause that exercise to be met with derision.

CASA HOUSE AND CRISIS CARE TO VICTIMS OF RECENT SEXUAL ASSAULT: RESEARCH CONTEXT

This research was developed and undertaken by CASA House, with data collected by the Counsellor/Advocates who staff the agency's twenty four hour a day, seven days a week, crisis care service. As CASA House provides the immediate context to the research, it is important to describe the agency's organisation and structure.

4.1 THE CASA HOUSE SERVICE MODEL

• Philosophy

The CASA House service model is based on advocacy for the rights of those who have been subjected to sexual assault. Its stated philosophy recognises sexual assault to be a crime that has significant emotional, medical, legal and social consequences for the victim. This philosophy also recognises that the elimination of sexual assault requires significant social including legal, reforms.

• Accountability

The Centre, which operates in association with the Royal Women's Hospital, is accountable to a Committee of Management whose membership is drawn from the Hospital and from the community sector. In turn, CASA's management committee is accountable to the Board of the Royal Women's Hospital.

• Services Provided

The services which CASA House provides are based on the Centre's philosophy and form a three tiered model of service delivery. The Centre provides:

- i. 24 hours, 7 days a week, crisis care services for victim/survivors of both recent and 'past' sexual assault and for friends, family members and on a consultation basis, for other workers. This includes both 'face to face' and telephone counselling services.
- ii. individual counselling, personal advocacy and group work to victim/survivors of sexual assault, their partners, families and friends;
- iii. a range of strategies through which to place the issue of sexual assault on the public agenda. This work involves community and professional education, government and media liaison and social research.

Together these service tiers enable CASA House to recognise and respond to the immediate and longer term physical, emotional and social needs of sexual assault victim/survivors and to contribute to the call for needed public reforms.

• Staffing

CASA House is staffed by seven Counsellor/Advocates, two office managers, a co-ordinator and five project workers.

• Service Demand

Since beginning operation in 1987, over 5,000 adult victim/survivors of sexual assault have used the Centre's services including, on average, 200 recent victims of sexual assault each year.

4.2 THE CASA HOUSE CRISIS CARE UNIT

The data collected for the purposes of this research relates to the services provided through the Centre's Crisis Care Unit. This central component of CASA's crisis services provides immediate face to face support for victims of recent sexual assault. The Centre's Counsellor/Advocates join with Hospital staff, Forensic Medical Officers and the police to provide a coordinated and comprehensive response to the victim at the point of significant crisis.

These tasks are carried out in an area that is used exclusively by CASA and which is located adjacent to the Royal Women's Hospital's emergency department. It is referred to as *the Crisis Care Unit*.

The Crisis Care Unit was designed specifically for the provision of emergency services to victims of recent sexual assault. It provides a private, non-clinical lounge like area in which the victim can be provided support and information. It also contains a bathroom, an examination room and an office space. The Unit's entrance provides direct off-street access. This enhances the victim's privacy and minimises the impact of the hospital environment.

• Referral to the Crisis Care Unit

There are a number of ways in which victims of recent sexual assault gain access to the Crisis Care Unit services. A woman may present to the

Hospital's emergency department; she may arrive at the Unit following a telephone conversation with a Counsellor/Advocate or arrive in the company of the police to whom she or someone else first reported the assault. It is this latter course that is the most frequent point of access.

• Crisis Care Unit Protocols

To ensure a high standard of service delivery, the work practices of those staffing the Crisis Care Unit are guided by protocols negotiated between CASA House, the Royal Women's Hospital, the Office of Forensic Medicine and Victoria Police.

These protocols give priority to the needs and rights of victims attending the Crisis Care Unit and are designed to:

- allow the victim optimum control over decision making regarding her medical, legal and support options;
- co-ordinate the activity of personnel in attendance at the Unit so as to minimise the trauma experienced by the victim;
- ensure that support and personal advocacy are readily available to the victim, her family and friends.

The overall quality of care provided through the Crisis Care Unit is monitored by quarterly meetings of representatives from each of the professional groups that are involved in the Unit's operation.

4.3 CRISIS CARE AND THE ROLES OF KEY PERSONNEL

For the purposes of this research, data was collected by the Counsellor/Advocates in the course of their standard duties. Therefore any interpretation of the data should be considered in the light of the roles played by the Counsellor/Advocates and by the other personnel who staff the Unit.

A number of formal roles come into play during the course of a victim's attendance at the Crisis Care Unit. Key among these are the roles played by the police, the Forensic Medical Physician and CASA's Counsellor/Advocate.

• The Role of the Police

As a matter of standard procedure, on receiving a sexual assault report, the police member is required to notify the Community Policing Squad (CPS). It should be noted that, frequently, this very first contact is with members of the general uniformed branch and constitutes an opportunity for discretionary exercise of judgement as to the validity of the victim's complaint. If at this level of the squad car, the foot patrol or the local police station desk, the victim/survivor is believed then the police member will contact the Community Policing Squad.

The CPS member is then required to take a brief statement from the victim in order to establish that a crime has been committed and to document preliminary details. Once this brief process is completed, the victim should be taken to the nearest Sexual Assault Centre Crisis Care Unit (Victoria Police Code of Practice, 1992).

The accompanying police are required to advise both the Sexual Assault Service and the duty Forensic Medical Officer of their impending arrival at the Crisis Care Unit. The Criminal Investigation Branch (CIB) will be notified that a sexual offences report has been received and depending on the circumstances of the assault, also may attend the Unit.

Once the victim has been met by the Counsellor/Advocate, received medical attention and undergone the forensic examination, the Community Policing Squad will accompany the woman either to a place where she can rest (e.g. her home) or to a nearby police station so that the full statement of complaint can be taken.

The taking of this statement, as discussed earlier, can be a lengthy and demanding process so that a period, on average, of some twelve hours may elapse from the time at which the report was first made to the police to the point at which this statement is completed. When the full statement has been taken the CIB can begin their investigation in earnest.

Before she finishes the initial reporting process, the victim may be required to answer further questions, return to the scene of the crime and assist the police in gathering any additional information, for example, through building an identikit image of the offender's physical appearance.

• The Role of the Forensic Physician

In Victoria, victims who pursue legal action as a result of a recent sexual assault, generally are required to be examined by a forensic physician. This examination fulfils two purposes. Firstly, it is designed to provide treatment for the acute sequelae of sexual assault. These may require emergency medical or surgical treatment and preparation for the management of sexually transmitted diseases or unwanted pregnancy.

Its second purpose is to build a viable case for the prosecution. The forensic examination involves the taking of specimens from the person of the victim, including those gained by way of a gynaecological examination, and the documenting of any other signs that suggest an assault has occurred.

Such examinations are carried out, almost exclusively by forensic physicians. It should be noted that it is not possible to provide the victim with a choice as to the gender of the forensic physician.

• The Role of the Counsellor/Advocate

The title 'Counsellor/Advocate' is, itself, a summary of the role that CASA staff play in the Crisis Care Unit. The particular functions that this role serves are based on the themes arising in the relevant literature.

A complimentary back drop is provided by the *structuralist school of social work theory* (Moreau, 1979) which calls for the consideration of 'power' (both personal and social) as a central issue in the counselling relationship. This perspective highlights as key therapeutic tools, the processes of empowerment, de-mystification, choice creation, normalization, and advocacy. These tools form the basis of the Counsellor/Advocate's role in the Crisis Care Unit.

Intrinsic to the structuralist approach is the acknowledgement in the counselling relationship of the influence that the sociopolitical context has on the experience of the individual. Given the aetiology of sexual assault, this sociopolitical context forms a concern pivotal to the Counsellor/Advocate role and, in particular, to the management of the relative powerlessness that is

experienced by the victim. This powerlessness is clearly in play in the context of the Crisis Care Unit where the victim must manage a range of demands placed upon her by those who are responding to her assault.

On this basis, the various components of the Counsellor/Advocate's role may be described as:

• Engagement

Hewitt and Scott apply crisis intervention theory to the support of victims of sexual assault when they note:

the (counselling) relationship is much stronger if involved at the beginning of the crisis. (1983:104)

Dr P. Bush, formerly Chief Police Surgeon, in his book *Rape in Australia* makes the point that for the victim, the medical/forensic examination and the police procedures often add to 'the crisis' rather than dissipate it (Bush, 1977).

As it is impossible to commence the counselling relationship at the point of principal crisis (i.e. the assault itself) the ideal starting point for optimal 'strength' in Hewitt and Scott's terms, lies at the beginning of the significant crisis of the forensic/medical examination and the police investigation.

Further, in terms of ongoing therapeutic involvement, it is the Counsellor/Advocate of all the personnel involved, who will have the most extensive, ongoing relationship with the victim. Their joint engagement is a priority for the service and is at a premium if secured early in the 'second stage' of crisis (i.e. on presentation at the Unit).

• Co-ordination

As Hewitt and Scott note, there is a range of personnel involved in the crisis intervention process, who:

often work from different perspectives and occupy different roles in relation to the victim. (1983:104)

Responding to this potential conflict of purpose, the State of California guidelines for crisis care of sexual assault victims recommends the appointment of a 'patient (read: victim) co-ordinator':

The individual victim needs a single source of sympathetic help in dealing with the numerous complexities of consent, examination for collection of evidence and problems which will of necessity arise in making choices about treatment. (California Guidelines, 1985: 6)

At CASA House's Crisis Care Unit this co-ordination, which needs to occur from the commencement of the victim's contact with the Centre, is undertaken by the Counsellor/Advocate.

• Information Provision

Abarbanel (1976) and Stevens (1980) emphasize the importance of full and accurate information provision to victims who are in crisis. Their concern is:

to ensure active choices are made by her, not for her, in regard to legal and medical options. (Stevens, 1980: 250)

The key issue here is the concept of decisions made by the victim rather than for the victim.

The victim/survivor must be given access to the information necessary for her to consent to a particular medico-legal course of action. The role of the Counsellor/Advocate, which is not vulnerable to the compromise of conflicting responsibilities, is to ensure this information has been provided to and considered by the victim/survivor before she is involved in any further medical, forensic or legal procedures.

• Advocacy

For Hardgrave (1976), Stevens (1980), Mastria et al and the NSW Sexual Assault Committee's Information Kit (1987) an advocacy function is an essential component of the counsellor's role. The counsellor must be imbued with the authority to ensure the victim's choices are respected by all those involved in the provision of crisis care. Mastria et al advise conceptualising the victim as a 'consumer' (p5) and urge that priority be given to ensuring the victim's requests/choices are understood by all personnel involved as being legitimate and warranting respect. Here the emphasis is the therapeutic function of crisis care and its potential to begin the process of return of emotional or psychological control to the victim.

The importance of advocating the 'victim's active choices' as the means for protecting the victim's rightful control, is reiterated in the handbooks published by the London (1984) and Wellington (NZ) Rape Crisis Centres (1985).

A self-evident requirement of this advocacy function is that it be carried out for the duration of the provision of crisis care.

• Support

Gilmore and Evans in *The Rape Crisis Intervention Handbook* give practical direction to nursing staff advising:

Whenever possible the counsellor is to be called prior to the gynae. work-up (read: medical/ forensic examination) so that the victim has additional support before undergoing what could be construed as a traumatic replay of the rape. (Gilmore & Evans, 1980: 43)

Both Hardgrave (1976) and Stevens (1980) warn against neglect of this 'third party' provision of support to victims who are encountering the medical and legal systems. Hardgrave summarises the role of the counsellor as that of working against a situation where:

the victim has been as humiliated by the agencies involved as by the rapist. (1976: 247)

Stevens' concern is that:

If there is no one available to serve as a buffer between the victim and the (medical, legal and social) agencies, personnel, people and procedures that blame the victim can hurt her further at a time when she is most vulnerable. (1980: 250)

These key themes of engagement, coordination, information provision, advocacy and support form the basis to the role played by the Counsellor/Advocate in the Crisis Care Unit.

As will be apparent, this role is designed to give priority to the victim's concerns and therefore can lead to a clash with the priorities ascribed by the police and by the forensic physician. This potential conflict of interest demands of the Counsellor/Advocate diplomacy as she attempts to represent appropriately the interests of the victim.

A detailed role and function statement for the Counsellor/Advocate is provided at Appendix A.

4.4 SUMMARY OF RESEARCH CONTEXT

CASA House and its Crisis Care Unit form the organisational context in which this research was undertaken. An understanding that the Centre is an advocate for the rights of victims of sexual assault is central to a proper interpretation of the research data.

The data was collected by the Centre's Counsellor/Advocates in the course of their responsibilities for:

- engagement with and support of the victim;
- coordination of the police and medical personnel in attendance at the Crisis Care Unit;
- information provision to the victim;
- advocacy for her rights and choices.

RESEARCH METHODOLOGY

5.1 THE RATIONALE

By way of introduction to the rationale that underpins the research approach adopted in this study, it is important to acknowledge the dilemmas that are presented in the task of researching violence against women:

It is clear that traditional forms of research and scholarship have failed to integrate women's experience of violence within their conceptual frameworks and failed, also, to acknowledge the potential for gender bias, thus skewing the direction of research and research outcomes. (Orr, 1991:117)

Orr continues by distinguishing a feminist alternative to such research approaches:

Feminist research, whether within a sociological or psychological paradigm, focuses on the victim's experience of violence, her means of survival, and her use of and satisfaction with services, such as police intervention or medical treatment. (Orr, 1991:117)

The orientation of this study is explicitly in favor of a focus on what can be usefully termed, the victim/survivor's own 'everyday lived experience' (Stanley & Wise, cited in Smith & Noble-Spruell, 1986:137)

Orthodox models of research have also tended to emphasise the process of 'research on women' rather than 'research for women' (Klein cited in Smith & Noble-Spruell, 1986:138). In contrast, the underlying objective of this study is to promote the interests of women, and in particular the interests of those women who have reason to report a sexual assault to the police. Thus, as Mies advocates, the starting point for this 'scientific quest' is the 'commitment to changing the status quo' (cited in Smith & Noble-Spruell, 1986:143). In regard to this study of police response to initial reports of sexual offences, the explicit intention is to provide compelling evidence in support of reforms that will significantly enhance the quality of the victim/survivor's experience of this response.

Finally, it must be acknowledged that traditional research models have been biased in favor of particular methodological styles:

Traditional research has overly relied on those methodologies (usually quantitative) that

emphasise rationality, objectivity, control, categorisation, detachment and distance and de-emphasise intuition, subjectivity, feeling, complexity and integration. In reality, however, quantitative research techniques often promise more veracity than they can actually offer and are often based upon hierarchical, manipulative and elitist relationships between the researcher and the researched. (Smith & Noble-Spruell, 1986:137)

In other words, this reliance on 'hard data' and so called 'objective' measures has skewed the development of knowledge and expertise away from that which can be gained through qualitative data and measures which reveal the experiential dimension of the researched. However, Jayaratne notes:

While qualitative research can convey the complexities of human situations, quantitative research can provide data from which to make generalised statements. These statements are important, both for advising policy makers in public opinion and devising strategies for bringing about social change. (cited in Smith & Noble-Spruell, 1986:140)

The fundamental object of this study, as already noted, is to contribute towards needed social change. For this reason, every attempt has been made to strike an effective balance between the presentation of both quantitative and qualitative data.

5.2 THE POPULATION

This study is intended to contribute to an understanding of victims/survivors of recent sexual assault and patterns in their experience of making a formal report to the police. In particular, the study is concerned with the population of victims of recent sexual assault who present to sexual assault support services, such as Centres Against Sexual Assault.

5.3 THE SAMPLING FRAME

The study is restricted to those victims of recent sexual assault who were provided services at CASA House's Crisis Care Unit (CCU) during the first six months of 1991. The only data recorded is that based on information that could be gathered whilst the victim/survivor was present at the CCU.

No data is provided on the victim's experience of police reporting either prior to or following her attendance at the CCU.

5.4 THE SAMPLING METHOD

The population sample was established through considering all victims of recent sexual assault who attended the Crisis Care Unit over a six month period. No one was included retrospectively and for the six month period of study the experiences of all victims attending the CCU were considered.

5.5 SAMPLE SIZE

The research sample consists of 117 victim/survivors who presented at the Crisis Care Unit over the six month period of the study.

5.6 DATA COLLECTION METHOD

As indicated in the review of recent research, there has been identified a number of complex themes that influence the decision to make, and the experience of making, an initial report to police. A questionnaire was developed to allow systematic collection, collation and analysis of data pertaining to these themes. This questionnaire (copy provided at Appendix 2) focused on those variables which were judged to be relevant to the issues identified in the literature search and detailed in Chapter Three. Research staff at the Social Work Department of the Phillip Institute of Technology, aided the development of this standardised questionnaire and data coding sheet (see Appendix B).

The questionnaire was self administered by the Counsellor/Advocate in regard to each victim/survivor seen at the CCU over the study period.

The ethical complexities associated with the task determined that data be collected only to the extent that it could be observed by the Counsellor/Advocate in the course of her duties at the Crisis Care Unit. The questions requiring demographic data, details of the decision to lodge a police report and data on the nature of the assault, were based on the information that is recorded by the Counsellor/Advocate as a matter of standard practice. Additional questions focused on observations made by the Counsellor/Advocate in the co-ordination of Crisis Care Unit personnel and

through her understanding of the victim's experience of police response. For example, Counsellor/Advocates were asked to rate police co-operativeness and degree of responsiveness to the victim's needs and to provide examples to substantiate their ratings.

In order that the data could be gathered unobtrusively, the questionnaire was designed to allow the Counsellor/Advocates to complete the CASA House standard Crisis Care Unit admission form and add additional information once the victim had departed the Crisis Care Unit.

All Counsellor/Advocates on the CASA House roster attended two training sessions on the use of the questionnaire.

A pilot project was conducted for a one month period in order to further familiarise the data collectors with their task and to identify any need for modification to the coding guide or data collection sheets.

In order to ensure confidentiality, no identifying information about the victims/survivors was recorded on the data collection sheets.

5.7 DATA ANALYSIS

The data was analysed using the *Statistical Package for Social Scientists* (SPSS).

Although manual cross-tabulations were attempted to establish any relationship between, for example, the demographic profile of the victim, the nature of the assault and police responsiveness, the data did not allow any findings that are of sufficient validity and reliability to be reported here.

Due to the size of the sample, analysis of the quantitative data has been limited to descriptive statistics (frequencies and percentages). The benefit of presenting the data in this way is its accessibility to a wider audience (Hatty, 1988:6).

Most of the qualitative data has been presented as a supplement to the statistical data. However, parts have been coded and analysed using SPSS and are presented in statistical as well as qualitative form. Where this occurred, in order to maintain consistency, one person coded the qualitative data.

5.8 LIMITATIONS

The limited resources CASA House had available to dedicate to this research prohibited the application of alternative methodologies. As a consequence this is a small study of victim/survivors of recent sexual assault and their perceived experience at the point of attendance at one of thirteen sexual assault centres in Victoria over a six month period. The inherent bias in this sample may place some constraints on the extent to which the study's findings may be generalised to other situations or to all victim/survivors of recent assault.

Further, this research is the documentation of qualitative data from the Counsellor/Advocate's perspective. While this creates a particular, and perhaps problematic, bias in the collection of the qualitative data, alternative approaches raise more serious ethical dilemmas. An obvious option would have been to request more active involvement in data collection from the victim/survivors themselves. However, the immediate aftermath of sexual assault places a range of intense pressures on the victim/survivor such that the prospect of an additional pressure posed by a request to participate in research becomes untenable and unethical.

Another option was to introduce an independent researcher at the points of initial report to the Police and at the Crisis Care Unit. However, the decision to proceed without introducing a more independent, objective research strategy was once again, both a practical and an ethical one. The prospect of introducing an independent researcher to a victim upon her arrival at the Crisis Care Unit raises questions as to the reasonableness of any expectation that she is in a position to give her informed consent to participation in such a study.

Equally, there is already a range of personnel interacting with the victim/survivor during her time at the Crisis Care Unit. An additional *player*,

such as an independent researcher, could place the victim/survivor's welfare in further jeopardy. Even if this independent researcher was introduced at some later point with the intention of gathering victim/survivors' reflections on their experience, ethical concerns would be raised and logistic difficulties encountered.

It must be acknowledged that the problems raised by this study's reliance on the Counsellor/Advocate as the key source of data are counter balanced by the very nature of the Counsellor/Advocate's role. Unlike any other of the personnel involved in the delivery of the crisis response to the victim/survivor, the Counsellor/Advocate has the distinct and official mandate to, as it were, see the world through the eyes of the victim. As her advocate and as the worker responsible for protection of the victim/survivor's interests, the Counsellor/Advocate is already *tasked* with the duty of hearing the victim's own experience. This role achieves a neat match with the intention of this research, which, as has already been emphasised, is to provide an account of the initial report process as it is experienced by the victim her/himself. The Counsellor/Advocate, by virtue of her formal responsibilities, is the person closest to that experience and therefore can be regarded as a legitimate data source.

CASA House is not alone in facing such restrictions on its options for independent research. For example, while this present study is dependent on data as collected by Counsellor/Advocates, the Victorian Community Council Against Violence research on rape in Victoria (1991) was based on data as recorded by members of the police force. In both instances there can be judged to be sufficient benefit to the research to justify their implementation despite their biases and to consider their subsequent findings as relevant to the public interest.

FINDINGS AND DISCUSSION

6.1 INTRODUCTION

The following presentation and discussion of the study's findings are organised into two parts.

The first part deals with data pertaining to the victim, to the offender and to the nature of the sexual assault. This section is confined to consideration of the relevant *quantitative* data that provides details of the sample's demographic characteristics and of the circumstances of the assault.

The second part considers findings related to the perceived quality of the victim's experience as she makes the initial report to the police. In this latter section both *qualitative* and *quantitative* data are considered so as to achieve a deeper insight into perceptions about the victim/survivor's experience of reporting to the police. Emphasis must be placed on the fact that the qualitative data is, in the main although not exclusively, based on the Counsellor/Advocates' perceptions. The weight of the quantitative data is evidence that every attempt was made to identify 'objective' and tangible measures by which to judge the quality of the victim/survivors' experiences. The qualitative data is used to provide greater insight into the implications of the findings established by the quantitative data.

It should be noted that aspects of the *qualitative* data are provided in the form of direct quotes from the study's data collection sheets. These have been distributed in the text according to the issue that is being addressed in the particular quote. Case numbers are used to indicate the quotes' distinct sources. Both positive and negative comments are included and every attempt has been made to ensure that the full range of qualitative data is represented in the text. However, the quotes are provided for the purpose of giving additional meaning to the quantitative data and should not, of themselves, be aggregated for the purpose of estimating in how many instances a particular quote might apply.

PART ONE

6.2 VICTIM DEMOGRAPHIC DATA

TABLE 1:
Victims/Survivors and their Gender

SEX	No.	%
Female	112	95.7
Male	5	4.3
TOTAL	117	100.0

The vast majority of victim/survivors attending the Crisis Care Unit were female (96%). This finding is consistent with the body of relevant research (VCCAV, 1991:18) and simply reiterates the established fact that, in the main, those who are subjected to sexual assault are women. It is a finding that supports the assertion that women are those who are most exposed to the public sector responses to sexual assault. In other words, it is principally women who either benefit from or are disadvantaged by, the quality of care they receive at the hands of those who play a role in crisis care of victims of recent sexual assault.

TABLE 2:
Victims/Survivors and their Age

AGE	No.	%
Under 15 years	5	4.3
15-20 years	39	33.3
21-30 years	47	40.2
31-40 years	18	15.4
Over 40 years	8	6.9
TOTAL	117	100.0

That a majority (78%) of the CASA sample were aged under 30 years, with a significant number (44%) aged under 20, is a finding consistent with other research (VCCAV, 1991:44) and one that requires some detailed consideration.

It is possible that adolescence brings greater vulnerability to violence and certainly:

Consultation with young women has revealed that often the assault has been her first sexual experience. (CASA, 1990:31)

However, it is beyond the scope of this research to specify, with any degree of certainty, the reasons behind the relative youth of those officially noted as being subjected to recent sexual assault. What can be emphasised without equivocation, is the fact that this (along side other data: e.g. VCCAV, 1991; LRCV, 1991) indicates that any one who is providing a service in response to recent sexual assault is providing a service to young people; any one who is trained to provide a response to recent victim/survivors must be trained to work with young people, and in particular, young women.

Yet, if the work of people such as Human Rights Commissioner Burdekin is considered credible, then it must be acknowledged that contemporary public sector systems (i.e. the police, the courts, welfare agencies) are not renowned for their sensitivity, relevance or ease of access to young people. For the quality of response to recent victim/survivors to improve, the quality of response to young people must also improve.

It must be recognised that a significant number, possibly a majority, of those determining whether or not to report to the police and then to continue pursuit of legal recourse are young, inexperienced and vulnerable to intimidation, if not exploitation, by those who are in positions of formal power and authority.

An acknowledgement that the reporting decision is frequently a young person's dilemma, is an essential preliminary step to strategic changes in the interests of an enhanced quality of response to victim/survivors of recent sexual assault.

TABLE 3:
Victims/Survivors and their Occupation
or Source of Income

OCCUPATION - INCOME	No.	%
Student	21	17.9
Benefit	38	32.5
Home duties	13	11.1
Non-professional	34	29.1
Professional	6	5.1
No income	3	2.6
Unknown	2	1.7
TOTAL	117	100.0

Sixty-four percent of victim/survivors were not engaged in paid employment at the time of the assault, with 32.5% being in receipt of a social security benefit.

It is important not to assume that these figures establish a relationship between occupation, income and sexual assault. Although these figures may suggest sexual assault is connected, in some way, to relative poverty, they may merely reflect the larger proportion of women, as compared to men, who are located outside the paid work force (ABS, 1990). They may also suggest that those on low incomes have fewer options from which to choose their course of action subsequent to an assault. However, once again a sample of this size does not allow meaningful interpretation.

Nevertheless, the data does indicate that a majority of this sample of victim/survivors had limited, if any, access to the level of economic resources that would support their 'recovery' or be required for the management of the personal and material 'costs' of the assault. As noted earlier, these costs can be substantial. In the absence of a supportive response from the police system, financial compensation for such markedly imposed debt is difficult, if not impossible to secure.

TABLE 4:
Victims/Survivors and their
Cultural Background

CULTURAL B'GROUND	No.	%
English speaking	92	78.6
Non-English speaking	24	20.5
Aboriginal	1	0.9
TOTAL	117	100.0

Seventy-nine percent of the sample nominated English as their first language; 21% being of non-English speaking backgrounds (NESB).

Approximately one-third of Victoria's population is of NESB. That only 21% of the study's sample was of non-English speaking background does not imply that women from NESB are less vulnerable to sexual assault. Rather, it provides a measure of the limited access that NESB women have to the legal system and to support services (Pittaway, 1991).

The 'reporting' system must consider that already one-fifth of those approaching it require a response that recognises Australia's cultural diversity; a response that can be formed only with adequate training and skill development:

In order to provide effective support to women of NESB, it is important that workers recognise and respect cultural differences and develop an understanding of the particular barriers encountered by those who are outside the dominant (Anglo) culture. (CASA, 1990:31)

As has been argued in relation to young people, a tolerant and skilled management of culturally induced complexity is not the reputation that the 'reporting' system has earned through its response to people of NESB.

This range of issues in respect to cultural diversity clearly applies also to Aboriginal women. As the data suggests, Aboriginal women are significantly under represented among those who have access to support services and thus are significantly disadvantaged when it comes to the exercise of their rights under law.

More so with Aboriginal people than with any other of Australia's cultural groupings, the 'reporting' system including related services such as victims' support and compensation services, has failed to secure a practice of, let alone a reputation for, humane and appropriate response. For example, Bligh's research reveals that public systems such as the police, the courts, protective and support services, are largely inaccessible and, therefore, irrelevant to Aboriginal women. (1983:101)

This is a circumstance that actively works against the ideal situation in which an Aboriginal woman is able to make a confident and free choice to exercise her right to report and to continue with that report. Therefore, it is a circumstance that contributes to the denigration of her citizenship status - the most fundamental of human rights.

TABLE 5:
Victims/Survivors and their Dis/abilities

DIS/ABILITY	No.	%
No known disability	95	81.2
Intellectual disability	10	8.5
Psychiatric disability	11	9.4
Physical disability	2	1.7

[In one case a person had two disabilities]

Eighty-one percent of the victim/survivors had no identified disability; 19% were considered disabled.

Once again, this data does not support interpretations such as: women with disabilities are less vulnerable to sexual assault. To the contrary, the fact that approximately one-fifth of the sample did have a disability suggests a heightened degree of vulnerability for disabled women. It also supports a view that the 'reporting' system must ensure it is well placed to respond to the particular issues raised when responding to a woman who has a disability. Certainly the data indicates an existing demand for that response.

Writing with specific attention to those who have an intellectual disability, but with relevance to the broad question, Johnson et al note, however, that people who have a disability:

like other marginalised groups in society, lack power over resources, relationships, information and decision making . . . this kind of powerlessness makes them particularly vulnerable to some kinds of crime and less able to gain redress once they are victims. (1988:19pp)

Johnson et al continue by observing that this vulnerability applies in particular to the crimes of sexual offences. Supported by training and appropriate procedures, it must be understood and actively upheld that:

Victims regardless of disability have the right to proceed with legal/police action. (Johnson et al, 1988:79)

TABLE 6:
Victim/Survivors and their Places of Residence
by Health Department Region

AREA	No.	%
Reg 6: Inner & West	61	52.1
Reg 7: North & East	15	12.8
Reg 8: South & East	26	22.2
Rural	1	0.9
Interstate	8	6.8
Homeless	6	5.1
TOTAL	117	100.0

[See Appendix C for a map of Health Department regional boundaries.]

Just over half of the sample resided in CASA House's official catchment area (Health Department Region 6); 35% of victim/survivors resided in areas that are serviced by other centres against sexual assault (i.e. Regions 7 and 8).

For this study's purposes the location of the victim's place of residence is relevant primarily to the issue of ease of access to follow-up support services.

The State Government's policy of regionalised service delivery to victim/survivors reflects the assumption that services are more easily and frequently used if locally based. It is a matter of some concern therefore if, as Table Six suggests, significant numbers of victim/survivors are not provided immediate access to those Centres from which they will most conveniently receive longer term support.

Obviously, for those of this study's sample whose usual place of residence was interstate or rural-based, a service located near to home was not a practical option; access to immediate medical and emotional care necessarily took precedence over the issues of service location. However, only in instances of medical emergency or other exceptional circumstances would this hold for women who are resident in metropolitan Melbourne. There are now sufficient metropolitan services to ensure that for the majority of women, priority is given to providing them access to the service to which they will most conveniently return for any follow-up support.

Given that the police play an influential role in determining which of the Centres a woman is referred to, it is important that police consider the longer term implications of what may otherwise appear to be merely an 'incidental' decision.

6.3 OFFENDER DEMOGRAPHIC DATA

Before considering the following findings, it is important to note that the victim/survivors were not asked for specific information regarding the offender/s or about their characteristics. Only information provided freely and spontaneously was recorded. As a consequence, a great deal of detail concerning the offenders is unknown. This naturally restricts interpretation of the offender-related demographic data.

In each instance, only data on one offender was collected and coded. However, the presence of more than one offender is recorded at Table 16.

TABLE 7:
Offenders and their Gender

SEX	No.	%
Female	—	—
Male	117	100.0
TOTAL	117	100.0

Table 7 supports the findings of earlier research: the majority (in this instance, all) of those who perpetrate sexual assault are men.

When considered alongside the data on sex of the victim/survivors, these findings support the assertion that sexual assault is a profoundly 'gendered' crime. While these findings hold no surprises, their significance should not be treated as incidental to the consideration of either the reporting decision or the reporting process. For if the majority of the victims of sexual assault are women, and the majority of the perpetrators are men, it is reasonable to suggest that this gender bias will generate a set of consequences relevant to consideration of the reporting issues. Former Chief Police Surgeon Bush describes these consequences in the following way:

To females it (sexual assault) is a bestial crime, a transgression of female liberty, an assault against all the rightful privileges (and) responsibilities . . . of womanhood. To the male it is an act which either does not exist or at best it may be considered an illegal, though understandable outlet for the release of those passionate desires contained in the male psyche which for one reason or another have failed to find legitimate outlet. (Bush, 1977:3)

Having identified the fact that women and men may differ in their perceptions of the nature of the crime, given that one predominantly is the victim and the other predominantly the offender, Bush continues by noting the public implications of these differences:

While differing male and female views of sexual assault co-exist, it is the male view which is legitimised through prevailing social policies and laws, as well as through attitudes and practices which govern, influence and effect our lives. (ibid)

It may be argued that much has changed in the fifteen years since the time of Bush's analysis. However, as this study's literature review reveals, there is sufficient contemporary evidence that the 'male view' prevails in both the attitudes and practices found within the reporting system to the extent that there are created for victim/survivors significant disincentives to reporting and to continuing the pursuit of that report.

TABLE 8:
Offenders and their Age

AGE	No.	%
15-20 years	9	7.7
21-30 years	40	34.2
31-40 years	18	15.4
Over 40 years	14	12.0
Unknown	36	30.8
TOTAL	117	100.0

While the rate at which the offender's age was recorded as 'unknown' weakens the significance of this data, there is evidence to suggest support for the VCCAV findings that a significant number

of offenders are young; most aged under thirty years (42%) (VCCAV, 1991:18).

These data also suggest a symmetry with the findings regarding the age of the victim and reiterate the point that sexual assault may play a significant part in the relationships between young men and young women.

TABLE 9:
Offenders and their Occupation or Source of Income

OCCUPATION/INCOME	No.	%
Student	8	6.8
Benefit	17	14.5
Non-professional	15	12.8
Professional	7	6.0
Unknown	70	59.8
TOTAL	117	100.0

The high rate of 'unknowns' makes impossible any confident interpretation of the significance of occupation/income data pertaining to the offender. It should be noted that this lack of data need not be taken as suggesting that the victim did not know the offender's occupational or income status. The 'unknown' category also includes those instances in which a victim/survivor did not volunteer this information to the Counsellor/Advocate, leaving as a moot point whether in fact she knew such details.

It is interesting to note that in the VCCAV research no reference is made to the occupational/income status of either the victim or the offender. This suggests the police do not collect such data. Given our dependence on police statistics, it seems problematic not to have recorded by the police all relevant and readily obtained, socioeconomic data, of which the offender's occupation/income is one example.

Another example of bias in this data collection system is reflected in the fact that the VCCAV research tables the victim's marital status but not that of the offender (1991:45).

An ideal situation would see a review undertaken of the data recorded by police in regard to both the victim and the (alleged) offender with a view to ensuring such data collection does not reflect sexist assumptions but is of contemporary social relevance.

TABLE 10:
Offenders and their Cultural Background

CULTURAL B'GROUND	No.	%
English speaking	69	59.0
Non-English speaking	20	17.1
Unknown	28	23.9
TOTAL	117	100.0

Again the rate at which 'unknowns' were registered places limits on the interpretations which can be made of this data. Nevertheless, the split between English speaking and non-English speaking background offenders may be said to match roughly that observed in relation to victim/survivors. Further, these figures may help to refute the popular (mis)conception that 'other' (i.e. non-Anglo) cultures are more likely to perpetuate sexual violence.

Because it appears that police statistics do not record the offender's cultural background, it is not possible to compare this study's findings with those established by the VCCAV.

Effective prevention or elimination of sexual assault can only be secured when the nature of the phenomenon is comprehensively understood. Inadequate data collection works against this understanding. Again, any opportunity to improve the collection of the data that is needed for an improved understanding of sexual assault should be supported.

TABLE 11:
Offenders and their Dis/abilities

DIS/ABILITY	No.	%
No disability	81	69.2
Intellectual disability	2	1.7
Psychiatric disability	3	2.6
Unknown	31	26.5
TOTAL	117	100.0

Despite the number of instances in which 'unknown' was recorded in regard to disability, it is possible to observe that fewer instances of disability were found among offenders (4.3%)

than among the victim/survivors of sexual assault (18.8%).

If this were to be verified by other research it would be possible to claim support for two important observations. Firstly, that those who perpetrate sexual assault are not disproportionately nor uniquely the visibly 'mentally ill' or 'intellectually disabled'. And secondly, that the greater social powerlessness created in regard to disability is correlated, not to the propensity to assault, but to the vulnerability of being viewed, in the eyes of the perpetrator, as ready prey.

TABLE 12:
Offenders and their Places of Residence by Health Department Region

AREA	No.	%
Reg 6: Inner & West	41	35.0
Reg 7: North & East	6	5.1
Reg 8: South & East	17	14.5
Rural	3	2.6
Interstate	16	13.7
Unknown	34	29.1
TOTAL	117	100.0

Little that is meaningful can be gleaned from Table 12. The sample is taken only from the population of victim/survivors who attended CASA House (an inner urban service) and, therefore, brings with it a geographic restriction which is biased towards 'inner metropolitan' assaults.

Nevertheless, the data on the offenders' residential areas may suggest that the perpetrator of sexual assault does not 'travel far from home' in order to commit the crime.

Certainly the fact that 70% of the victim/survivors were able to identify the offender's place of residence is consistent with data, discussed later, that reveals in a majority of instances that the offender is not a stranger, but someone who is known to the victim.

6.4 DATA ON SUBSTANCES PRESENT

TABLE 13:
Substances that the Offender was under the Influence of at the Time of the Assault

SUBSTANCE	No.	%
None	49	41.9
Alcohol	20	17.1
Pills	3	2.6
Marijuana	4	3.4
Not known	45	38.5

[There were three cases where the alleged offender was under the influence of two substances and one case where the alleged offender was under the influence of three substances.]

TABLE 14:
Substances that the Victim/Survivor was under the Influence of at the Time of the Assault

SUBSTANCES	No.	%
None	76	65.0
Heroin/Methadone	3	2.6
Alcohol	25	21.4
Pills	7	6.0
Marijuana	4	3.4
Unknown substance	3	2.6
Not known	3	2.6

[There were four cases where the victim/survivor was under the influence of two substances at the time of the attack.]

The statistics presented in Tables 13 and 14 relate to the presence of mind altering or mood changing substances at the time of the offence. The data collection questionnaire did not direct those providing the data to distinguish between voluntary or involuntary, prescribed/licit or illicit, drug use. Nor did it require the noting of the extent to which either party was affected. Nevertheless, in four cases, it was specified that the victim's drug consumption was due to the offender's force or deceit. Additional cases may remain unspecified.

Approximately one-fifth of both the offenders (17%, Table 17) and the victims (21%, Table 18) were under the influence of alcohol at the time of the assault. However, it is not possible to specify the extent to which either party was affected by

said consumption, nor to identify the amount that had been consumed.

What the data does suggest is that in the majority of instances neither alcohol nor any other drug was present or that the same was used in small quantities with little influence on the situation. The data certainly does not support the misconception that holds alcohol or other drug use to be a direct cause of sexual violence.

6.5 SEXUAL ASSAULT DATA

TABLE 15:
Nature of Assault

LEGAL DEFINITION	No.	%
Aggravated rape	17	14.5
Rape	80	68.4
Attempted rape	9	7.7
Indecent assault	9	7.7
Unknown	2	1.7
TOTAL	117	100.0

The nature of the assault was registered according to the relevant category of offence as defined under the Crimes Act [1958, s.2a.(1)]. In lay terms it is possible to describe, albeit crudely, 'aggravated rape' as penetration with additional violence, 'rape' as penetration, 'attempted rape' as attempted penetration and 'indecent assault' as covering behaviour such as unwanted, sexualised touching. It should be noted that following recent work undertaken by the Law Reform Commission, the letter of this section of the Crimes Act has been altered substantially; for example, 'common law' rape has been repealed and the category of 'aggravated rape' eliminated.

Table 15 confirms that the majority of those attending the Crisis Care Unit are victim/survivors of recent rape, with a number recently subjected to 'aggravated rape'.

On this evidence, it is clear that the work of those staffing the Unit (the counsellor/advocates, the police, the medical personnel) takes place at the very time when the victim/survivor is in significant crisis; at that moment when she is first

aware that she has been reduced to emotional rubble (Sullivan, 1986:51). The timing of this meeting point with the victim demands of all workers involved skilled and sensitive interaction which acknowledges the victim/survivor's emotional state and which aids, rather than impedes, her first steps on the complex and lengthy journey of recovery.

TABLE 16:
Offender's Relationship to Victim

RELATIONSHIP	No.	%
Stranger	36	30.8
Family Member	3	2.6
Friend/Acquaintance	47	40.2
Current/Ex-partner	13	11.1
Multiple Offenders	17	14.5
Unknown	1	0.9
TOTAL	117	100.0

[*'Multiple' is not a relationship category, but indicates instances in which more than one offender was involved. In none of these instances, 17 in total, was a relationship recorded.*]

In the vast majority of instances, the offender shared with the victim an existing relationship as family member, partner, friend or acquaintance. These are the very relationships in which, by tradition, it is assumed the exercise of violence is precluded. As the relationship of the victim/survivor to the offender was not specified in cases involving more than one offender this figure may even underestimate the number of instances in which the offenders were previously known to the victim.

This data merely reiterates findings of numerous studies, confirming that while the stranger does pose some danger, this is far out weighed by the propensity for sexual violence found in the commonplace and every day relationships that men have with women. The relevant point here is the observed tendency among police to view with greater scepticism the victim/survivor who alleges rape at the hands of someone known to her. The VCCAV observes on the basis of their research into police records that:

Stereotypical attitudes about who victims and offenders are and the circumstances in which

attacks happen lead to categorisation of only some circumstances as 'genuine'. Other instances that do not fit the 'classic' rape scenario have more difficulty in being accepted. (VCCAV, 1991:82)

Rigid stereotypes and assumptions about the circumstances in which 'actual' or 'serious' sexual assault occurs, are deeply problematic particularly if, as appears to be the case, a majority of victim/survivors, offenders and 'rape circumstances' do not conform to these perceptions. For the offender, these stereotypes can be to his benefit in that they may mean he escapes apprehension. For the victim, however, such prejudice can cause her to feel that she is the one who is under investigation, the one who is on trial. This clearly constitutes a key component of her experience of secondary victimisation.

TABLE 17:
Location of Assault

VENUE	No.	%
Public place	33	28.2
Victim's/offender's home	56	47.9
Other home	12	10.3
Vehicle	12	10.3
Work place	3	2.6
Unknown	1	0.9
TOTAL	117	100.0

The 'location' data is another element of this study's sample that flies in the face of popular assumption about the nature of sexual assault. As Table 16 indicates, in the majority of instances the assault was perpetrated within a home environment. If the 'home' categories are grouped with 'work place' and 'vehicle', these locations account for 70% of assault venues.

It was not possible to desegregate 'public place' into, for example, 'streets', 'parks' or 'licensed premises'. Nevertheless, there is sufficient meaning to be derived from this data to suggest support for the argument that, although:

women and children have become increasingly fearful of being a victim of sexual assault, especially in public places and consequently have altered their lifestyle in very restrictive

ways . . . people's fears about being raped are at variance with the real risks. (VCCAV, 1991: 6)

Just as the stranger is not the pre-eminent danger, neither is the dark alley the sole or even main harbourer of the offender or the offence.

PART TWO

6.6 DATA ON REPORTING TO POLICE

TABLE 18:
Was the Assault Reported to the Police?

	No.	%
Yes	93	79.5
No	24	20.5
TOTAL	117	100.0

In nearly 80% of instances the sexual assault that was perpetrated against the victim/survivor was reported to the police.

As was noted in the discussion of recent research, it is estimated that less than 10% of all sexual assaults are reported to the police. However, this study's very high reporting rate reflects the sample's bias: given the majority of victims gain access to the Unit through contact with the police, any sample of the Unit's service user population will be biased towards those who report to the police.

In this instance, at least 84 of the 93 victim/survivors who reported to the police had already done so before arriving at the CCU. This may be taken as confirmation that of those victims who seek a response from the public systems, a majority's first contact point is with the police. This practice of direct police reporting places a considerable burden on the police to ensure that their initial response inspires confidence rather than intimidates or trivialises.

The fact that 84 victim/survivors were accompanied by the police to the Crisis Care Unit following a direct report to the police, indicates

that the police responded to a significant number with sufficient seriousness to pursue the report to the point of a forensic/medical examination.

However, the study's qualitative data indicate that the initial contact with police can be extremely negative:

This was the second time that the rape had been reported to the police. No police action was taken when the first complaint was made. Victim/survivor reports that police laughed at her and told her to 'Go away'. Victim/survivor requested that CASA make a complaint regarding this situation. (Case no. 36)

Initial report to local police resulted in their attendance but lack of action. Victim/survivor was then supported by family to report to another station; which was then pursued by them. (Case no. 48)

When the victim originally rang the police (immediately after the assault), two uniform members went to his home. After hearing his story, these police told him 'Filthy faggots don't get raped' and left. A few days later, victim/survivor reported to a friend who made some complaints and assisted the report process again. (Case no. 99)

It is clear that police management of this initial contact with the victim/survivor of recent sexual assault will be influential not only to the success of the subsequent investigation. Their conduct is also a powerful influence on the victim/survivor's experience of the consequences of seeking assistance. A negative experience might well generate a reluctance to approach other services which in turn may generate debilitating isolation from skilled care and support.

Indeed, each instance of an inadequate initial response helps build a public reputation that the decision to report a sexual offence is at best a gamble as to the quality of care that a victim/survivor will receive. The public perception that the police are inconsistent in their responses or that on the basis of prejudice (such as that demonstrated in Case 99 above) discriminate against certain 'classes' of victims or certain 'types' of assaults, contributes to what is acknowledged to be a crisis in public confidence concerning the efficacy of the criminal justice system.

TABLE 19:
Who Reported the Assault to the Police?

WHO REPORTED	No.	%
Victim	49	52.7
Relative/Friend	25	26.9
Counsellor/Advocate	8	8.6
Other	10	10.8
Unknown	1	1.1
TOTAL	93	100.1

In approximately 53% of the 93 instances where a report was made to the police, the report was lodged by the victim/survivor her/himself. In the remaining instances, 27% of reports were lodged by someone known to the victim/survivor and in eight instances it was the Counsellor/Advocate who lodged the initial report with the police.

In those instances where the Counsellor/Advocate lodged the report, the victim's first contact with the 'reporting' system was with CASA House. The decision to involve the police was made by the victim after discussion with the Counsellor/Advocate. Having taken that decision, the victim/survivor requested that the Counsellor/Advocate contact the police. It is worth noting at this point that in another 24 instances where the victim/survivor first presented to CASA House, the woman concerned decided against reporting to the police.

Those occasions where the report was lodged not by the victim her/himself, but by someone other than the Counsellor/Advocate, raise the question as to whether or not the victim/survivor consented to the lodging of the report. For example, in one instance the victim did not proceed with the police report because:

Victim decided that she didn't like the police's attitude towards her. Parents had decided on police involvement — not victim. (Case no. 111).

It is relevant to affirm that there is no legal obligation on the victim to report the offence. For an adult woman, therefore, the decision as to whether or not to report to the police is a choice between two ostensibly viable options; a decision that ideally should be made by the victim her/himself.

It seems a worthy principle that, wherever practical, the victim's consent should be given to the lodging of a police report. Thus, in instances where the report is made by a person other than the victim, priority should be given to ensuring that the victim is consenting to the processing of that report. In the interests of minimising secondary victimisation, it is highly preferable that situations where investigation proceeds against the express wishes of the victim herself be avoided.

As detailed earlier, there exists a range of disincentives and a range of incentives that influence the outcome of this decision as to whether or not to report to the police. Table 20 (below) considers some of the reasons that victim/survivors cite when deciding not to make a report to the police.

TABLE 20:
Reasons Why the Assault was Not Reported to the Police

REASONS FOR NO REPORT	No.	%
Offender known to and/or feared by, victim	16	66.7
Fear of police/legal process	17	70.8
Did not want friends/family to know	14	58.3
Due to victim's disability	3	12.5

[Coding allowed for up to three reasons to be registered for each victim/survivor as to why the attack was not reported to the police. The first 'reason' category includes instances where the victim/survivor feared that because the offender was known to her the police would not believe her and/or that she would face future reprisals by the offender.]

As already noted, of the sample of 117 victim/survivors, 24 made a decision not to report to the police. The overwhelming message provided by these 24 victim/survivors is that where a choice is made not to report to the police it is a choice made on the basis of fear: fear of the offender (68%), fear of the police and fear of court (70%), fear of family reaction and fear of friends' reactions (58%).

Although the assault itself will have already generated in the victim a deep and pervasive fear, by the time she is in a position to determine whether or not to report to the police, the actual assault itself is over: she has survived. However, as she considers the options before her, she discovers that while the literal assault is past, the fear continues as does her heightened sense of vulnerability (CASA, 1990). For example:

Victim/survivor rang police station twenty four hours after the assault. CPS visited and when victim/survivor explained she had bruises, the policewoman asked her to pull her pants down to see. Victim/survivor then decided not to proceed further. (Case no. 21)

Victim/survivor fearful of legal process and did not want to be further traumatised. (Case no. 42)

. . . fear of involvement in legal process (i.e. giving evidence in court). (Case no. 44)

Victim/survivor very ambivalent about proceeding with legal action — very aware how she would be treated in court given she went back to offender's flat and had sex with him in the past. (Case no. 61)

. . . there was a lot of peer pressure and family pressure (not to proceed). Decided that although the offenders deserved to be put in jail, she couldn't 'lag' on them. The victim did not want to go to police station or have anything to do with police . . . (Case no. 73)

Victim decided not to proceed as rapist was known to the victim and her circle of friends and did not want the others to know. (Case no. 109)

Clark and Lewis interpret the social implications of this fear when they write:

Women and children are afraid, and made to be afraid, to seek the protection and redress of the law. Their best strategy is to remain silent, and when one considers that it is the rapist who has most benefit from this silence, it is hard to escape the conclusion that social attitudes, and their articulation in the legal process, operate to protect not the victim but the rapist. As things stand it is being raped that is punished, and it is being raped that is a crime. (Clark & Lewis, 1977)

The incentives to reporting are a mix of desire for redress, desire to meet community expectation that formal justice be allowed to take its course and the desire that the offender not have an opportunity to place others at risk (London Rape Crisis Centre, 1984:39; McEvoy & Brookings, 1984:43; Women and Rape pamphlet, 1986:7). The disincentives include fear of reprisals, fear of secondary victimisation and fear of making an emotionally costly investment in a process that in all probability will deliver a disappointing outcome. The weight given to these variables may be different according to whether it is the victim taking the decision or someone else.

Furthermore, as noted in an earlier section, much of the relevant research supports as valid the assessment that the best option is not to report: no protection can be guaranteed for the victim afraid of the offender's reaction to the police report; the police do not always provide a response that is supportive of the victim and the court process is traumatic. Family and friends either may be unable to cope with the fact of the assault, or may adhere to stereotypical notions as to the circumstances in which assault occurs, blaming rather than supporting the victim. A decision not to report avoids angering the offender, and removes the victim from contact with both the police and with the courts, while leaving intact the option of not 'going public' with family or friends.

However, the cost of the decision not to report is high, both for the community and for the victim. In an immediate sense, little can be done to allay a victim's fear of the offender's reprisal, but through legal system reform much can be achieved in the interests of minimising the trauma that a police report initiates and through targeted community education, friends and family members can be educated to act as carer, not judge or jury.

6.7 DATA ON COOPERATION BETWEEN POLICE AND CASA

The following data is presented under the heading of 'cooperation'. However, it is also an indicator of the quality of care provided to the victim/survivor. As suggested earlier, the extent to

which there is present genuine cooperation and understanding between all the personnel involved, will strongly influence the quality of the victim's experience of the services which she receives.

TABLE 21:
Did the Police Advise the Royal Women's Hospital of their Pending Attendance at the CCU?

ADVISE ARRIVAL	No.	%
Yes	51	60.7
No	17	20.2
Not recorded	16	19.0
TOTAL	84	100

Of the total sample of 117 victim/survivors, 93 were involved in a report to police. In 84 of these 93 instances (a figure arrived at by subtracting from the original 93, the eight instances where the report was lodged by the Counsellor/Advocate and the one instance where the relevant information is missing) the victim/survivor or someone else reported directly to the police. Table 21 deals with issues that are relevant to these 84 victim/survivors.

Although the rate at which the 'notification' data was 'not recorded' limits the usefulness of this data, it is clear that, at least on 17 occasions, the police failed to notify the hospital of their pending arrival. The significance of prior notification to the quality of service provision requires some explanation.

The majority of those attending the Unit do so after the close of business hours (see Table 23). After hours, the duty Counsellor/Advocate is contacted by way of a pager system. If she is not contacted prior to the arrival of the police and the victim/survivor, a substantial delay can be caused to the progress of the crisis care services. It is the Counsellor/Advocate's role to fulfil the functions for which she is responsible as described in *The Research Context*; functions which are essential to the appropriate care of the victim/survivor. Thus, the crisis care protocol requires that the Counsellor/Advocate be present and conversant with the victim/survivor before any aspect of crisis care services other than emergency medical care, is provided.

A failure by the police to give prior notice that they will be attending the CCU prevents the Counsellor/Advocate from being in attendance by the time the victim arrives. Such a delay provides an otherwise avoidable extension of the time that will pass before the victim/survivor is free from the initial 'reporting' process.

Victim/survivor was initially accompanied to Crisis Care Unit by male police officers (not CPS). Victim/survivor first met a female CPS member at the end of the CCU process. No notice was given to RWH about pending arrival. Forensic physician was already speaking with victim/survivor before Counsellor/Advocate arrived. (Case no. 54)

Even where the crisis care service is required during business hours, there are similar advantages to the practice of prior notification in that early warning ensures adequate preparation for the victim's arrival.

In either case, if there is prior notification that the police are accompanying a victim/survivor to the CCU not only can the Counsellor/Advocate be present when the police and the victim arrive, but the Crisis Care Unit itself can be well prepared for use (e.g. warm, set out appropriately) allowing the necessary services to be delivered smoothly, effectively and efficiently. Most importantly, prior notification avoids the situation in which the victim is subjected to heightened discomfort because of unnecessary delays.

TABLE 22:
Of Those Who Reported Directly to the Police, the Approximate Time from Receipt of the Report to Attendance at the CCU

TIME LAPSE BETWEEN REPORT AND CCU	No.	%
Less than 1 hour	14	16.7
1-2 hours	15	17.9
2-3 hours	16	19.0
3-5 hours	18	21.4
More than 5 hours	16	19.0
Unknown	5	6.0
TOTAL	84	100

Of those who reported the sexual assault directly to the police, only 17% were taken to the Crisis Care Unit within an hour of making the report. In 40% of cases, between two and five hours had passed and for almost one-fifth (19%) of the victims, more than five hours had elapsed, before the police brought them to the Unit:

[The CIB members] insisted on victim/survivor giving statement before attending the Crisis Care Unit for support and medical attention. Up to twelve hours elapsed before she attended the Crisis Care Unit. (Case no. 46)

Victim reported the rape to the police at 6.00 pm and arrived at the Crisis Care Unit at 11.00 pm. (Case no. 112)

In some instances, it appeared that police members had no knowledge of the formal procedures for response to a victim of sexual assault:

Police officers who accompanied the victim/survivor were not familiar with the CCU protocol. (Case no. 54)

None of the CIB or Uniform Branch knew of CASA's existence or of the protocol. (Case no. 112)

The consequence of this extended time delay between the point in time that the police first receive the report and the moment when they and the victim arrive at the appropriate Crisis Care Unit is not merely a problem of a test of patience, nor is it a matter of only debatable concern. The longer a victim is delayed in her access to a Crisis Care Unit's services, the longer she is delayed in her access to:

- medical assessment and treatment;
- the opportunity (otherwise denied her because of the risk that forensic evidence will be lost) to wash, change her clothes, toilet, eat or drink;
- information and support other than that which can be readily provided by the police;
- emotional support such as that provided by a Counsellor/Advocate;
- support from and direct contact with family and/or friends.

It is the physical and medical consequences of such delays (for example, in relation to internal injuries and the risk of pregnancy) that hold the greatest potential for tangible 'secondary abuse' of the victim/survivor of sexual assault. By virtue of who it is that has the power to determine when the victim shall be taken to a Unit, this abuse can be described as secondary abuse that is overtly initiated by the system.

For instance, it was noted in regard to a woman who had a disability that she was:

interviewed . . . without the presence of a (third party) . . . Police decided that it was not worth proceeding with after checking victim's under-pants at police station! Consequently, victim was not brought into the Unit, necessitating medical follow-up to take place at a later date. (Case no. 105)

Paradoxically from the perspective of the investigation, such delays also imperil the evidence that only a forensic/medical examination can secure, and thereby present a threat to the development of a successful case for the prosecution; not 'just' a threat to the well being of the victim!

Nevertheless, to understand the significance of this data, it is important to consider the reasoning behind such delays. The following table summarises the primary reasons given by police when delays exceeded more than one hour (i.e. for 70% of those victim/survivors who reported directly to the police).

TABLE 23:
Primary Reasons for a Lapse of More Than
One Hour Between Time of Report and
Attendance at CCU

REASON FOR TIME LAPSE >1 HOUR	No.	%
Statement, or lengthy preliminary statement, taken before attendance at CCU	15	23.1
CIB commencement of investigation	30	46.2
Victim confusion due to shock/disability	5	7.7
Medical examination conducted elsewhere	4	6.2
A second report necessitated because of poor reaction by police to initial report	3	4.6
Police took Victim/Survivor home first	2	3.1
Inappropriate police action	2	3.1
Unknown	4	6.2
TOTAL	65	100.0

In 46% of cases, the lapse of time between reporting the assault to the police and attendance at the CCU was due to the fact that the Criminal Investigation Bureau (CIB) had already commenced their investigation. In another 23% of cases the time had elapsed because the police had decided the priority was to take the victim's statement or to have her make a lengthy preliminary statement. In relation to one such occasion, the Counsellor/Advocate noted that:

I received a phone call from police at midnight informing me that victim was now being taken to the scene of the crime before attending the Unit . . . When I expressed my concern about the victim/survivor not being brought into the Unit immediately, the officer concerned told me to do so would mean that 'valuable time would be wasted' in apprehending the offender. I again indicated that I understood that it was protocol for police to bring victim/survivor into Crisis

Unit after a brief interview. (case no. 38)

Concern expressed to police regarding delay in attending Unit — given injuries sustained by victim — stab wound to hand which required stitching. CIB had commenced investigation and they had apprehended offender — concern that physical needs neglected in pursuit of carrying out the investigating. (case no. 90)

The implications of these delays that appear to be created for the purpose of speeding police investigation are that, at least by default, the police are judging the victim's physical and emotional well being to be of only secondary importance. What remains problematic about such judgements is that they also are, by their impact and consequence, medical and psychological judgements:

CPS visited and when victim/survivor explained she had bruises, the policewoman asked her to pull her pants down to see. (case no. 21)

Such assessments of the victim/survivor's condition are being made by personnel who are neither trained nor mandated to undertake such a role. What is problematic, apart from the arguably unethical nature of such judgements is that where the statement or the investigation takes priority over the medical examination, there is an implicit judgement made by the police that the victim does not require acute medical care. However, instances such as internal bleeding or injury to the genitalia will not be 'diagnosed' by someone who is not medically trained nor will a victim necessarily immediately disclose to the police the full extent of her injuries, pain or discomfort.

For example, in one instance, poor provision of information combined with inappropriate judgement resulted in a delay that carried the potential of significant medical consequences:

Police did not bring woman to Crisis Care Unit because she was worried about leaving her family to have the medical examination. Poor information given . . . The CPS and CIB became involved . . . They did not explain the need for a medical/forensic examination . . . a medical examination by a woman doctor on roster (not

a forensic physician) ensued. The victim has physical injuries as follows: deep grazing to hand requiring tetanus shot and dressing; swelling over left eye; general bruising; gravel in her vagina (showing penetration had occurred). This woman should have been medically treated earlier, i.e. immediately after the assault. (Case no. 14)

In another instance, the victim required medical treatment of an order that could not be provided at the Royal Women's Hospital. However:

Victim had a large lump on forehead, sore neck and back of head, knife scratches on his face, chest and length of forearm (offender had a knife), complaining of sore ribs and an inability to use his injured arm. The CIB's attitude was non-believing and blaming. At 3.05 am the police took the victim, assuring me they were taking him to the (name) Hospital ten minutes away for medical attention. They continued to be antagonistic and rude in manner. At 4.35 am I was paged for a phone call from Dr [name], of (that nearby) Hospital, seeking advice on what sort of medical examination to conduct. The CIB had only just arrived at the hospital (one and a half hours after leaving the Royal Women's). I explained the examination needed. (Case no. 15)

The possibility of 'non-acute' medical consequences, for example, sexually transmitted diseases and unwanted pregnancy, also provide a compelling argument for greater emphasis on speeding the victim's access to medical care.

It cannot be assumed that the apparent urgency of the investigation is prompted only because the offender's 'scent is on the wind'. Were this always the case it may be possible to mount a stronger defence of the police ordering of priorities. However, the opportunity of, or need for, such urgent pursuit of the offender is more often exceptional than it is common. In a majority of instances, the identity of the offender is not an issue, rather the investigation will centre on the question of whether or not the victim/survivor was consenting to sexual intercourse.

Anecdotal evidence supports a hypothesis that priorities are also directly influenced by administrative demands, including pending shift change overs and conflicting aims between the

Community Policing Squad members and members of the Criminal Investigation Bureau.

Nevertheless, the decision not to prioritise the victim's access to crisis care services is a decision which involves a range of judgements. Put bluntly, in respect to some of these, the police have neither the training required nor the authority to make such judgements.

TABLE 24:
Time of the Day Victim/Survivor Attended CCU

TIME	No.	%
Business Hours	27	23.1
After Hours	70	59.8
Not Known	20	17.1
Total	117	100.0

The majority of the 117 victim/survivors (70) attended the CCU at times other than standard business hours.

While the relevance of these data may not be immediately obvious, two key messages can be established. Firstly, the fact is that a majority of victim/survivors are in need of crisis care services at times when they would otherwise be sleeping, resting or at leisure. This supports the view that a humane system of response to the crisis generated for the victim who is reporting a sexual assault needs to recognise and respond to issues such as exhaustion, sleep deprivation and the emotional and intellectual disorientation caused by extreme tiredness; a dimension to the victim's experience that can only exacerbate the impact of the assault itself.

In addition, that a majority require services after hours is an important consideration in terms of resource allocation; particularly given the demands placed on the resources of both the Community Policing Squad (CPS) and the Centres Against Sexual Assault.

For example, during most of the evening non-business hours period, the CPS operate only two cars which in turn are staffed by only two members (LRCV, 1991a:21). These four police members are required to meet a range of demands

of which a sexual assault 'call' is but one. On the other hand, centres against sexual assault must operate 24 hours a day, with staffing levels and budgetary restraints that make the expense of after hours work prohibitive.

As community awareness of the criminal nature of sexual assault and of the availability of support services increases, so too does demand for crisis care services. The clustering of that demand around non-business hours is predictable, understandable and inevitable. However, the facts of this matter must be reflected in both the quality of response afforded the victim, including sensitivity to the level of her exhaustion, and in the protection of resources allocated to providing the essential service of immediate crisis response to victims of recent sexual assault, whether that crisis occurs during the day or at night.

Once the victim/survivor has arrived at the Crisis Care Unit, but prior to the medical/forensic examination, the Counsellor/Advocate seeks an opportunity to speak with the victim. However, it should be noted that this expectation of immediate access to the victim by the Counsellor/Advocate has been, at times, a source of some concern to the police. For reasons associated with prompt pursuit of the investigation and out of concern that no more time be spent in the Unit than is absolutely necessary, the police and, on occasions, the forensic medical staff, have seen the Counsellor/Advocate's initial contact with the victim as superfluous.

The rationale for this early contact between the victim and Counsellor/Advocate is detailed in Chapter 4 and elaborated upon at Appendix A. Nevertheless, it is important to reiterate that the victim/survivor of sexual assault presents more than investigative/forensic concerns. She brings with her a set of rights and entitlements as well as personal needs to which someone must provide an unequivocal response. As has been discussed earlier, it is to these other dimensions of crisis care that the Counsellor/Advocate is uniquely placed to respond and therapeutically, such response best commences as early as is practicable.

However, in recognition of the range of demands to be met at the time of crisis care provision, the CCU Protocol directs that this time should not extend beyond 15 minutes.

TABLE 25:
Of those Who Reported Directly to the Police,
Approximate Initial Time Spent by the
Counsellor/Advocate With the Victim/Survivor

TIME SPENT BY C/A	No.	%
< 15 minutes	48	57.1
> 15 minutes	24	28.6
Unknown	12	14.3
TOTAL	84	100.0

While in a majority of instances the Counsellor/Advocate initially spent less than 15 minutes with the victim/survivor, in over one quarter (28%) of the cases, more than fifteen minutes elapsed. It is not possible to specify the greater extension of time, however, the Protocol directs the Counsellor/Advocate to discuss any significant extension of this initial time with both the police and with medical staff. Again, the data is best understood in light of the reasons given by the Counsellor/Advocate for the extension of time.

TABLE 26:
Reasons for the Counsellor/Advocate Spending
More Than 15 Minutes with the Victim/Survivor
on Arrival at the CCU

REASONS FOR TIME LAPSE > 15 MINS	No.	%
V/S ambivalent re. police involvement	5	20.8
Victim/Survivor confused about options	16	66.7
Language difficulties	2	8.3
Waiting for added police personnel to arrive	1	4.2
TOTAL	24	100.0

In 67% of instances where this initial contact extended beyond the 15 minute mark, the time was used to clarify the victim's medical, legal and support options. This involves, for example, providing information about the role of the forensic physician, discussing the option of a support person during the examination or creating an opportunity for the victim to contact her family or friends.

In another 21% of these situations, the victim/survivor was expressing ambivalence about proceeding with the police report. In such instances, the Counsellor/Advocate supports the victim as she determines her decision; a decision that also will affect her medical care options. For instance, if she proceeds with the police report she will be required to have a forensic examination; if she chooses to not proceed she can nominate her own preferences in regard to the receipt of medical care.

Efficient provision of services implies a concern with the time taken to provide those services. However, it is also the case that efficiency is compromised if initial services are made shoddy by being rushed which in turn, can cause problems requiring solution at some later point in time. It is possible to argue that a most fundamental right of anyone in need of medical care is the right to give informed consent prior to receipt of that care. Generalising from the particular, and emphasising the importance of consent in the provision of service to those who have been sexually assaulted, it is possible to argue that the function that ensures the victim/survivor is giving her informed consent to all procedures, not just medical, is not only important, but indispensable to effective, efficient and ethical crisis care.

6.8 INFORMATION AND SUPPORT DATA

The key reason that the Counsellor/Advocate finds herself adding to the length of time taken prior to the medical examination, appears to be directly linked (in 67% of cases) to a problem in the provision of adequate information to the victim prior to her arrival at the CCU. The following table identifies the extent to which the victim appeared to have been provided with adequate information prior to her contact with the Counsellor/Advocate.

TABLE 27:
The Victim/Survivor's Understanding of Medical and Legal Procedures Based Upon Information Given by the Police

DEGREE OF UNDERSTANDING	No.	%
Very good/clear understanding	11	13.1
Fair understanding	36	42.9
Minimal understanding	30	35.7
No information given by police	4	4.8
Unknown	3	3.6
TOTAL	84	100.0

In 56% of instances, victim/survivors were provided with information sufficient to form an adequate understanding of the medical and legal procedures:

Gave clear information about rights in relation to legal options. Sympathetic. Flexible in terms of meeting victim/survivor's needs. (Case no. 49)

CPS spent considerable time going over options and legal information. (Case no. 60)

However, in 40% of cases, the victim/survivor had been given little or no information by the police.

Poor information provided by the police. The need for a medical/forensic examination was not explained. (Case no. 14)

While there may be some debate as to the nature and detail of 'appropriate information', the base line test is whether, or not, the woman is given information about:

- her legal rights, including the option of making a statement of 'no further police action';
- the role of Centres Against Sexual Assault including their Crisis Care Units;
- the CCU protocol and the role of the Counsellor/Advocate;
- the forensic/medical examination and the role of the forensic physician;
- her right to make contact with her family and/or friends;

- the fact that she should feel able to indicate at any point in the process that she feels too tired to proceed.

As discussed in Chapter Three, information provision is essential if the victim is to experience a sense of control as she encounters the various systems. It is certainly a precondition for her informed consent to whatever action is being taken.

While the Counsellor/Advocate retains overall responsibility for ensuring the victim/survivor is given ample opportunity *to seek and to receive* information, all personnel have a responsibility to ensure the victim *is provided* with adequate information. Indeed, certain aspects of information provision can only be undertaken by personnel with the relevant expertise: the police have the expertise to explain the investigative process; the forensic physician the expertise to detail the medical issues.

If the police provide the victim with adequate information early in the reporting process, the quality of the victim's experience is greatly enhanced. And, if this information were provided prior to attendance at the Unit, there would be reason to predict a drop in the amount of time the Counsellor/Advocate would require with the victim before the medical examination is able to proceed. The length of time which the police spend with the victim prior to her arrival at the Unit would seem to provide an adequate opportunity to ensure the victim/survivor is given at least the minimum information necessary for her to experience greater control within the reporting process and, for her to build a basis for and an understanding that she is entitled to informed consent to each step that is to be taken in that process.

6.9 FORENSIC PHYSICIAN DATA

In the chronological progress of crisis care services, the next step is the forensic/medical examination. Therefore, the following data relates to the arrival of the forensic physician at the Unit. It is presented here because the timing of this third 'arrival' (the others being the victim (most often in the company of the police), and the Counsellor/Advocate is yet another factor that influences the length and the quality of the initial police reporting process as experienced by the victim/survivor herself.

TABLE 28:
Approximate Time Between the Victim/Survivor's Attendance at the CCU and the Arrival of the Forensic Medical Officer

TIME LAPSE BEFORE FORENSIC M.O. ARRIVAL	No.	%
Forensic Practitioner unable to attend	4	4.8
Up to 30 minutes	41	48.8
30 minutes to 1 hour	22	26.2
More than 1 hour	6	7.1
Unknown	11	13.1
TOTAL	84	100.0

In most cases (75%), the forensic medical officer arrived within an hour of the victim/survivor's attendance at the Crisis Care Unit. This must be considered a speedy response, particularly given the constraints and demands under which the forensic practitioners work.

However, alongside the time lapse between the initial report and the victim's arrival at the Unit, coupled with possible delays in the arrival of the Counsellor/Advocate, the time taken for the forensic physician to arrive constitutes another of the variable time periods that when added together reveal a reporting process in which the sheer length of time involved is sufficient to make it harrowing, regardless of how that time is spent.

To reiterate, in addition to this variable waiting time, the reporting system also requires the victim/survivor to give time to make a preliminary statement, possibly answer some initial questions from the CIB; to talk with the Counsellor/Advocate; to talk with the forensic physician; to undergo a medical/forensic examination; to make a full and detailed police statement; to return to the scene of the crime; to answer further questions etc. The assault may have occurred at the end of the day and by the time the initial reporting process is complete, some twenty-four hours or more can have elapsed since the victim/survivor last slept. It is a problem of timing.

6.10 STATEMENT TO POLICE DATA

TABLE 29:
The Form of Police Statement Made
by the Victim/Survivor

FORM OF STATEMENT	No.	%
No statement	6	6.5
Full statement	59	63.4
No Further Action statement	19	20.4
Not recorded	9	9.7
TOTAL	93	100.0

While 63% of victim/survivors proceeded with police action to the point of making a full statement, 26% determined that they would either make no statement at all or make a statement of 'no further action'. While perhaps as few as one in ten victims of sexual assault reports to the police, it may be that, of that 10%, close to another one in three withdraw from the reporting process. Again, this data needs to be considered in light of the reasons behind the decision to discontinue with police investigation.

TABLE 30:
Primary Reasons Why Victim/Survivor
Made Either No Statement or a Statement
of No Further Police Action

REASON FOR NO POLICE ACTION	No.	%
Recommendation made by the police	6	24.0
Fear of, or lack of faith in, the police	4	16.0
Offender known to Victim/Survivor, fear of reprisal	4	16.0
Shocked state of victim	3	12.0
Perceived effect on other relationships	3	12.0
Fear of legal process	7	28.0
Other	1	4.0
Reason not indicated by Victim/Survivor	4	16.0

[Seven people nominated two reasons why no further police action was requested.]

Table 30 suggests that the primary reason why the decision not to proceed further with police investigation can be distinguished according to whether the police recommended such a decision or whether the victim/survivor identified grounds on which to discontinue the reporting process.

Of those reasons nominated for discontinuing, 24% were based on the recommendation of the police as reported to the Counsellor/Advocate by the victim/survivor. For example:

Woman informed me that the CIB members had laughed at her and advised her not to proceed with police action as she was a prostitute. (Case no. 9)

CIB advised woman that because three months had lapsed since the offence occurred, there was no point in making a statement. (Case no. 22)

[The CIB] advised the CPS that the woman would make a hopeless witness. (The victim) made a No Further Action statement due to police advising her that the legal process would be very difficult. (Case no. 23)

After a three and a half hour interview with two CIB officers, on her own, she was told that she had not clearly said 'no' . . . They then advised her to proceed with a No Further Action statement. (Case no. 110)

Other reasons for deciding not to proceed match closely the themes identified in the earlier literature review.

The 'problem of timing' was evident in the 12% for whom "shocked state" was nominated as the primary reason.

Victim became extremely distressed. (Case no. 25)

. . . victim had great difficulty communicating — in shock. (Case no. 69)

Another 28% of reasons given related to the fear of repercussions on other relationships or fear of reprisal at the hands of the offender:

Victim's bag stolen with her address in it. She fears reprisals from offender so made a No Further Action statement. (Case no. 31)

In one instance (referred to as 'other'), the victim/survivor elected pursuit of an alternative legal proceeding being the breach of a pre-existing intervention order.

However, fear of the consequences of continuing with the police report including fear of the legal process created 44% of the nominated reasons:

Victim was scared of the legal process and was supported by police in a decision of No Further Action. The attending police indicated to me that due to her psych. (psychiatric disability) issues, she would not make a good witness. (Case no. 16)

Not wanting to go through court hearing but wanted crime registered. (Case no. 94)

While the sample is too small to make confident interpretations (N=25 being those who reported directly to the police, but chose to discontinue through either no statement at all or a statement of no further action), the findings do support the themes identified in previous research and provide additional argument for reporting system reforms that will minimise the disincentives to reporting and maximise the incentives to continue with the reporting process.

TABLE 31:
If a Statement was Made, When Did It Occur?

WHEN STATEMENT WAS MADE	No.	%
Before attending the Crisis Care Unit	15	19.2
Immediately after leaving the Crisis Care Unit	33	42.3
After the victim/survivor had rested	26	33.3
In the days following the assault	4	5.1
TOTAL	78	100.0

[This data includes statements of No Further Action.]

Of those who reported directly to the police and who proceeded to make either a full statement or a statement of no further action, nearly 20% had made that statement prior to arrival at the Crisis Care Unit; that is prior to receipt of medical care or additional emotional support.

Another 42% were to make their statements immediately after attendance at the Unit. Therefore, prior to being left free to choose to spend her time, for example, resting or receiving support from family or friends, 42% of the victim/survivors not only had to make an initial police statement, be interviewed by police, be taken to the CCU, meet with the Counsellor/Advocate, undergo a forensic/medical examination, but now were to proceed to provide police with a full and detailed statement; a process that can require many additional hours of the victim's time; a process that of itself can be a significant deterrent to continuing with the report:

Victim felt overwhelmed with police procedures, e.g. photo's etc.; at one point almost reluctant to proceed. (Case no. 83)

However, in over 38% of instances the victim/survivor was able to exercise the option of resting (including waiting for a period of some days) prior to the provision of the police statement.

What is unclear here, is whether or not there were specific differences in the circumstances of those who made a statement after resting and those who made the statement immediately after the Unit. Nevertheless, the data do suggest that it is possible, at least in some instances, for priority to be given to the welfare of the victim; that is for the victim's need for rest to take precedence over police administrative or investigative demands.

The following data suggests that these measures of the quality of care provided to the victim/survivor may be directly correlated to the attitude of the police members involved.

6.11 DATA ON POLICE ATTITUDES

Tables 32 & 33 relate to the Counsellors'/Advocates' perceptions concerning police attitudes as conveyed by their behaviour towards victim/survivors. The tables quantify the degree to which the Community Policing Squad members and the Criminal Investigation Bureau members were perceived to be 'co-operative' and 'responsive' to the victim.

TABLE 32:
How Co-operative and Responsive were the
Community Policing Squad to the
Victim/Survivor's Needs?

RESPONSE TO VICTIM	No.	%
Very responsive	20	21.5
Responsive	48	51.6
Not responsive	13	14.0
Antagonistic	5	5.4
Unknown	7	7.5
TOTAL	93	100.0

TABLE 33
How Co-operative and Responsive were the
Criminal Investigation Branch to the
Victim/Survivor's Needs?

RESPONSE TO VICTIM	No.	%
Very responsive	2	2.2
Responsive	9	9.7
Not responsive	16	17.2
Antagonistic	11	11.8
Unknown	55	59.1
TOTAL	93	100.0

[Once again, some overlap between the categories was apparent in the assessments of the treatment of sexual assault victim/survivors by Criminal Investigation Branch (CIB) members.]

Table 32 makes clear that the overwhelming perception is that the members of the Community Policing Squad (CPS), in the main, are both co-operative and responsive to the needs of victims/survivors of sexual assault. In 73% of instances CPS members were rated as either 'responsive' or 'very responsive'.

In the qualitative data, adjectives such as 'patient' (Case no. 13), 'kind' (Case no. 44), 'supportive' (Case nos. 13, 44, 46, 49, 69, 81, 90), 'empathetic' (Case no. 54), 'nice' (Case no. 77) and 'sympathetic' (Case no. 108) were used by victim/survivors themselves in assessments of the Community Policing Squad's co-operation and responsiveness to the needs of the victim/survivors.

The data found in Table 33, pertaining to the Criminal Investigation Branch, is more limited in its value in that for nearly 60% of cases the relevant

data was not recorded. It may be that in a majority of those 'missing data' instances the CIB had not yet been involved or had not yet had contact with the victim.

Nevertheless, in 67% of those cases where it was possible to provide data (N=38), and in stark contrast to the perceptions of the CPS, CIB members were seen to be either 'not responsive' or 'antagonistic'. In only 29% of those instances about which the relevant data were collected, the CIB were considered 'very responsive' or 'responsive'.

The qualitative data provides additional insight into the contrast between 'responsive' or 'very responsive' behaviour and 'not responsive' or 'antagonistic' behaviour. The following quotes provide examples of both the CPS and the CIB equivalent of a 'very responsive' or 'responsive' service.

Offered lots of support and were prepared to transport victim's friend to collect her children so she could spend the night with the victim. (Case no. 12)

CIB responsive to victim/survivor's level of distress and wanted her to understand that it was totally her decision whether or not to report. (Case no. 25)

Gave the victim the option of going to sleep before making the statement. (Case no. 29)

Wanted her to be absolutely sure she was up to making a statement — no pressure. (Case no. 30)

Accepted victim's decision of No Further Action statement and made arrangements to take the statement when convenient to the Victim. (Case no. 31)

When, some weeks later, she decided to make a statement of complaint and request legal action to recommence, CIB members were encouraging of this and co-operative. (Case no. 44)

CIB wrote supporting letter for Ministry of Housing transfer and advocated for woman to utilise CASA. (Case no. 45)

Very encouraging of her decision to proceed with legal action. (Case no. 55)

Acknowledged difficulty in reporting when offender ex-partner, but were encouraging of her rights. (Case no. 62)

CIB agreed to 'allow' victim to rest before giving full statement. (Case no. 64)

Because the victim had difficulty in communicating, the CPS officers communicated through drawings; and were emotionally supportive. (Case no. 69)

CPS officers reassured victim that it wasn't her fault. When it was clear by the end of the CCU that the victim would probably not go ahead and report, the CPS completely respected decision and acknowledged that it would be difficult for her to go through police action due to her past experience with police. (Case no. 73)

Horrific circumstances involved with assault. Police response good. (Case no. 78)

Adhered to procedure. Non-judgemental. (Case no. 79)

Seemed understanding about victim's decision not to proceed with reporting. (Case no. 109)

From these examples, it is possible to deduce that police are perceived to be responsive to the victim's needs when they:

- affirm her rights under law;
- support and respect her decisions irrespective of whether or not she chooses to continue with the report;
- are sympathetic to the victim's emotional state;
- are sensitive to her need for rest;
- provide her with additional assistance in managing the consequences of the assault.

However, it is not always the case that a consistent quality of police response will be provided to the victim. At times the different sections of the Force that are involved in responding to sexual assault complaints may be in some conflict as to what should be the priority.

For example, the CPS with its greater emphasis on victim welfare may find itself in conflict with the CIB's investigation priorities. In some instances,

the CPS members may manage this conflict by deferring to the CIB:

Given CIB attendance, CPS took a back seat. (Case no. 25)

On other occasions it appears possible for the CPS members to act as advocates to the CIB on behalf of the victim, sometimes successfully:

(CPS) very hyperactive in acknowledging need for victim to rest prior to statement taking — advocated for this with CIB over phone. (Case no. 92)

And, at other times, with lesser success:

(CPS) advocated with CIB for victim to go home and rest. (CIB) wanted victim to continue (Case no. 97)

There may be occasions when the CPS members feel obliged to be the apologist for the CIB:

(CPS) de-briefed with the woman after CIB left and indicated that they (CIB) had to challenge her to see if she was lying. The CPS then indicated that they believed her story. (Case no. 7)

What is clear from these findings is that in a majority of instances, the presence of CPS members has a markedly positive impact on the quality of the victim/survivor's experience of police-reporting.

On at least one occasion the CPS members were observed to be playing this intermediary role in relation to other than CIB police members:

After a number of attempts made by the victim to make a complaint, the Uniform Branch were not interested in being involved. CPS members were later contacted and were very responsive, e.g. believed the victim and proceeded to take the statement without the abuse inflicted by Uniform Branch. (Case no. 99)

What is significant about this example is the involvement of uniformed, non-CPS (by the fact of their dress, non-CIB) police. It is beyond the scope of this report to consider, in any detail, the response of these police who, in the main, are literally, the first to 'set eyes upon' the victim who is reporting direct to the police. However, it can be noted that where a report is first received

by a member of the general uniformed branch, the CPS and CIB members are involved only at his/her initiative.

The receipt of a report can occur at a police station, over the telephone or by way of a passing squad car and in each instance there will be involved a degree of discretion as to whether, or not, the uniformed member/s decide the report should proceed. In some instances the outcome of this most immediate contact can be horrific, for example,:

Police initially approached victim as she was crawling along city street distressed. Their approach was so insensitive, i.e. eight male police officers approached her causing such distress that she refused to have anything to do with them. They evidently called in a female police officer who calmed her down and put her in a police car. They then took her back to the scene of the crime where they wanted her to go back into alleyway where she had been raped. Became hysterical and police decided to leave her with friends and not to pursue with action. Victim/survivor then brought to hospital. (Case no. 63)

The key point is that the member who is the first police person involved, in the main, will not be a member of the sections that have the most experience or training in responding to sexual assault; a fact that, as the example above implies, can create circumstances in which the victim is treated to a response that is far from ideal.

While a majority of CPS members were perceived to be responsive to the victim/survivors' needs, another 19% were rated as 'not responsive' or 'antagonistic'. And of those cases about which information was gathered, 67% of CIB was considered 'not responsive' or 'antagonistic'. Again, the qualitative data provide some further insight into the nature of this response.

In some instances it appears that part way through the process, the police members who were attending the victim, suffered a bout of compassion fatigue:

Gave information in a clear fashion but were not sympathetic to the woman's concerns. One member stated, 'Make up your mind, we haven't got all bloody day. (Case no. 8)

The CPS were initially responsive but became less responsive once it was clear that it was a 'consent' matter with little forensic evidence. (Case no. 113)

Initially responsive. However, they became irritated and angry towards the end of the process as victim was tired, hungover, and had problems remembering details. (Case no. 116)

On other occasions members' attitudes were observed to be callous and insensitive:

Appeared unconcerned regarding the needs of the victim. (Case no. 23)

Indifferent (Case nos. 32, 36)

. . . member appeared annoyed at being called out because only one offender had raped the victim. When I pointed out that the victim/survivor was extremely tired and wanted some rest he indicated he would decide how long questioning would be necessary, regardless of how victim/survivor felt. (Case no. 33)

Male police officer . . . appeared unable to understand why the victim/survivor, after being threatened by the offender, was too afraid to 'run away' from her assailant. (Case no. 35)

At times, this insensitivity was accompanied by behaviours that were perceived to be overtly threatening:

One member . . . was hostile and threatened young woman with a (admission to a) detention centre. (Case no. 4)

Victim was informed by CIB that if she was found to be lying, she would have to pay all their wages and that she would be charged. (Case no. 22)

Victim described police as 'lecturing' her about false reporting and perjury. Police persistent in wanting to see victim's bruises even though victim didn't want to show them. Victim described approach as being quite forceful. (Case no. 94)

In two of the five instances where the victim/survivor was male, there were also specific but inappropriate accusations regarding the man's sexuality:

The CIB ordered me (the Counsellor/Advocate) from the room even though the victim asked that I stay with him. They then proceeded to 'grill' him in a very aggressive non-believing manner. They threatened him with false reporting and made accusations that he was lying and a homosexual. (Case no. 15)

Were receptive to receiving the report. However, questioned victim about whether he was a paedophile. (Case no. 112)

On occasion the victim appeared to have been subjected not only to the questioning required for the taking of a statement, but to the interrogation normally reserved for those charged with a criminal offence:

Aggressive questioning which appeared to doubt the victim/survivor's story (she had intellectual disability and became very confused and distressed). She felt disbelieved, doubted and blamed. (Case no. 41 and refer Case no. 15 above)

Victim went back to the police station to make a full statement. CIB member entered room whilst CPS member getting coffee and accused her of making it up because, 'she is a sad and lonely girl — all your friends don't believe you, they think you're a liar'. Victim ran out of police station and went home. (Case no. 98)

Although the study was limited to the collection of data based on that observed in the Crisis Care Unit, in one instance an additional example of the problematic consequences of police insensitivity was cited:

CIB rang woman at place of employment . . . breached woman's confidentiality, i.e. stated they were police etc. to other employee. Attempted to persuade victim to change statement to full complaint (Case no. 94)

On the basis of this additional qualitative data, it can be asserted that the police, whether members of the CPS or of the CIB, were perceived to be unfair, if not inhumane, in their treatment of victim/survivors of sexual assault when they:

- became impatient with or intolerant of the victim;

- showed little or no sensitivity to the victim's emotional and/or physical state, including her need for rest;
- overstepped the boundaries of their legitimate role i.e. asked to examine her physical injuries;
- demonstrated a level of prejudice in response to, for example, the victim's sex, or intellectual disability;
- threatened or sought to intimidate the victim;
- 'interrogated' the victim rather than 'took her statement'.

As noted in review of recent research, the police treatment of a victim is a key influence on the victim's own attitude to the prosecution; a key influence on the outcome of the prosecution. In this regard, Connors' observations are worth repeating:

. . . it cannot be overemphasised that the best evidence, which is essential to successful prosecution, can only be gleaned from the best treated complainant (i.e. the victim). Intelligent and enlightened treatment of the complainant from the human perspective thus becomes the critical key in the success of the police function of law enforcement. (Connors, 1988:24)

It is important to note that it appears quite possible, at least in a significant number of instances, for the police (either CPS or CIB) to behave in ways that are seen to be and are experienced as, cooperative and responsive; in ways that aid rather than hinder the prosecution process.

The data identifies support for the previous research that suggested there exists among the police, significant incidence of poor to appalling treatment of the victim. However, the data does not support any notion that it is an occupational hazard, inherent to the police role, that the member must behave in ways that means s/he will be seen in a negative light.

6.12 SUMMARY OF RESEARCH FINDINGS AND DISCUSSION

Although there are points at which the data provided by this study do not support strong interpretation, what it does signal is a significant consistency with the predictions established by previous research. Several of the study's findings stand out.

In the first instance the findings confirm that sexual violence is a very 'gendered' crime. The overwhelming majority of the sample of adult victims were women (96%), of whom the vast majority (83%) had been subjected to rape or, using the terminology of earlier legislation, to 'aggravated rape'. In each instance the assailant was male (100%).

Also firmly established was the fact that the nature and circumstances of the assaults were substantially at variance with popular or stereotypical notions about rape. Only 30% of assailants were previously unknown to the victim/survivors and the majority of assaults (65%) occurred in the domestic rather than the public sphere.

Close to 80% of the victim/survivors were shown to be young women under the age of thirty, with nearly 50% aged under twenty. In contrast, on the data available, it appears that the perpetrators were distributed across an older age group with a significant number aged 30 years or over. Only 9% of offenders were categorised as being under the age of twenty. This supports the analysis that there exists a significant power differential, in this case based on age difference, in favor of the offender over the victim.

In 80% of instances a formal report was lodged with the police, 50% of these at the initiative of the victim/survivor her/himself, with the majority of the remainder instigated by a friend, family member or bystander. This suggests that the decision to report to the police is not always a decision taken by the victim.

Where a woman decided not to lodge a formal report, her decision was, in the main (70%) motivated by fear of the legal process itself. The fact that the offender had prior knowledge of the victim also proved a significant deterrent to reporting (67%) as did fear of the reaction of family members or friends (58%).

In instances where the victim/survivor's first point of contact with the reporting system was with the police, nearly 60% had experienced more than a two hour delay before arrival at the Crisis Care Unit; that is before receipt of emotional and medical support. Seventy percent (70%) of these delays were caused by commencement of the formal police investigation, including the taking of preliminary or full statements.

Sixty percent (60%) of reports occurred outside business hours which suggests support for concerns regarding the possible exhaustion of the victim, even irrespective of the assault.

On arrival at CASA's Crisis Care Unit, 57% of victim/survivors spent less than 15 minutes with the Counsellor/Advocate prior to the commencement of other procedures such as the forensic/medical examination. In 66% of those instances where a longer period of time was taken, the victim/survivor expressed confusion about her options and required additional information before she could choose to proceed further into the reporting process. In another 21% of occasions where the Counsellor/Advocate spent greater than 15 minutes with the victim/survivor, the purpose was to assist her to resolve her ambivalence about ongoing police involvement.

The prior provision, by the police, of information concerning the victim/survivors' medical and legal choices was viewed as being appropriate in over 50% of instances. However, for the remainder (44%) the information provided had been less than adequate.

In regard to the decision as to whether or not to proceed with the reporting process to the point of making a full statement to police, the option of not proceeding was taken by 30% of victim/survivors; 23% electing a 'statement of No Further Action' and another 7% providing no statement at all. In these instances, a range of reasons for the 'not proceeding' decision was cited. Twenty-four percent (24%) chose this option on the basis of police recommendation. Another 28% nominated fear of the legal process as the most significant deterrent and 16% specified fear of the police as their key reason. An additional 16% expressed fear of reprisal from the offender and another 12% were concerned about the impact on family members or friends. In 12% of instances, the

victim's own emotional and physical state made proceeding too arduous a prospect.

Of the 70% who proceeded to the point of making a full statement, 42% did so immediately following their attendance at the Crisis Care Unit. In contrast, 19% had already made their statement prior to arrival at the Unit while another 37% gave a full statement at a much later point after a period of rest.

The study's format distinguished the degree to which the Community Policing Squad was seen to be 'co-operative' and 'responsive' to the victim, from the degree to which these qualities were reflected in the attitudes and behaviour of members of the Criminal Investigation Branch

(CIB). In over 70% of instances the CPS members were rated as responsive to very responsive with only 19% identified as being unresponsive to antagonistic. In contrast, where the data was relevant (i.e. CIB members had attended the Unit) and recorded, 11 members (29%) were seen to be responsive to very responsive, while 27 CIB members (71%) were either unresponsive or overtly antagonistic.

These findings confirm that the provision of initial police response to reports of sexual assault requires detailed consideration of a complex of factors. Without a more concerted effort to understand these issues, there remains intact the danger that the reporting system simply reiterates the impact of the assault.

CONCLUSION

The legitimate, growing public concern that there be a more effective and just response to violence against women reflects an enhanced community awareness that these crimes are among the most neglected, the least understood and yet among the most devastating of human experiences. These emerging themes in public consciousness have a potent and particular relevance to the crimes of sexual offences which are, as the literature confirms, among the most hidden of crimes against women.

The relative invisibility of sexual violence is evidenced by what is estimated to be massive under reporting to the police. This aspect to sexual offences creates an ethical incentive to ensure that those minority of victim/survivors who come before the formal reporting system receive an optimal, rather than a variable, quality of response. This is both a humane and a justice agenda.

However, the securing of this optimal response requires an understanding of the barriers that inhibit appropriate management of sexual assault reports and of the practices that constitute inappropriate behaviour towards victim/survivors. These barriers and behaviours are clearly identified in the literature, are confirmed by this study and most recently, to a large extent, are reflected in the 1992 Victorian Police Code of Practice in relation to sexual offences.

The Code provides a substantial and welcome mechanism by which to commence a more systematic transformation of the reporting process towards the ultimate goal of ideal response. While it remains to be seen whether the Code will directly impact on the actual practices of police members, it also remains a worthwhile task to reiterate the reasons why such a standardising policy is needed.

This study *To Report Or Not To Report*, alongside previous research, provides such reiteration. The key findings that are established by this study match those described in Chapter Three.

They clearly reiterate that rape remains a most 'gendered' crime, something to which women are uniquely subjected; something which men exclusively perpetrate. These findings place gender, sex role stereotyping and sexist attitudes as key issues that must be accounted for in police training, procedure and accountability mechanisms. As numbers of other authors have emphasised, sexist attitudes and the resultant behaviour have no

place in an effective and humane response to victim/survivors of sexual assault.

This study also highlights the fact that a significant proportion of women who undergo the 'initial reporting process' are young women. This observation also holds relevance for police training and procedures. Although relations between the police and young people have received some attention in terms of concern with police response to young offenders, the issue of young people, in this instance young women, as victims of crime has been less emphasised. This study suggests that the relative youth of victim/survivors who present to the police is a central, not a peripheral issue and should be a fact taken account of at both the training and procedural levels.

Although somewhat tangential to the principal focus of this study, the need for adequate data collection was revealed. That data collection occurs on aspects of the victim/survivor's 'profile' but is not collected in regard to the 'alleged' offender, is symptomatic of practices that may benefit from a process of review; the principle being that accurate, public information including that which is needed to dispel myths and stereotypes, requires appropriate data collection. It is in the public interest to have data collection systems that are not biased by sexist or dated assumptions about the relevance of certain demographic material.

In regard to the *Problem of Timing*, this study certainly confirms that the role of the police as a point of first contact is real and, therefore, potentially and actually a potent factor in the victim/survivor's first experience of publicly identifying herself as a victim of rape. Ninety-one percent (91%) of victim/survivors involved in this study reported first to the police. There can be no argument that the police are central to the initial reporting process and by virtue of this fact, carry enormous significance as influences on the quality of victim/survivor's experience of the public reporting process. Given the acute and longer term impact of sexual assault, this initial contact point also carries significance for the victim's journey to survival. Frequently, it is the police that represent the first of a series of opportunities in which the public system of response can distinguish for the victim a reality that is antithetical to the rape itself. However, inappropriate conduct, prejudice, poor judgement and single minded concern with the investigation can cause the reporting system to be experienced as an extension of the assault.

At the most concrete level, the judgements made by police at this early point either build barriers or open access to, urgently needed medical and emotional support. These judgements must be structured so as to ensure they do not involve the police in either direct or indirect assessments of the victim/survivor's physical and emotional state; assessments for which the police are neither mandated nor trained.

On the *Problem of Repercussions* it is important to take note of the role played by fear, not only fear of the offender but also fear of the legal process itself, in the creation of disincentives to reporting and incentives to not reporting. Because generalised fear is a predictable and realistic reaction to rape, the initial reporting process must be structured so as to minimise any further generation of fear within the victim/survivor. This is yet another example of a goal that is consistent with both the humane treatment of the victim/survivor and with the undertaking of effective investigation. Conduct and practices which either overtly intimidate or threaten, or which, by omission, leave the victim/survivor without adequate information about the reporting process and its various stages, serves to consolidate rather than eradicate this state of fear. This study has highlighted the important part in this 'fear diminution' agenda that is played by the provision to the victim/survivor of information, the opportunity to discuss and clarify that information and the chance to express and to have respected, her views and opinions about her preferred course of action.

This study's qualitative data establishes some basis from which to assert that *The Problems of Definition, of Stereotyping, of allegedly False Reporting and of Police Attitudes* are all intricately linked. Where the attitudes of police members were demonstrably at their worst, allegations of false reporting appear to have been based on a range of prejudicial responses to the victim/survivor. Operating out of attitudinal stereotypes based on, for example, the victim/survivors' age, her/his relationship to the offender, her/his perceived sexuality, these police were shown to perpetuate, rather than diminish, the impact of the assault, to the point that the victim/survivor's own definition of her/his experience was in dispute.

While attitudinal change is a worthy goal, it is behaviour and conduct that is the most relevant

concern in the context of personnel performing their professional duties. Through police training, accountability mechanisms, clear complaints procedures and standards of conduct such as those provided by the Police Code of Practice, needed behavioural change can be secured such that the variable attitudes held by individual police, including sexism and racism, can be made less influential. Certainly training which debunks the myths and stereotypes about rape, which informs police about non-sexist, non-racist behaviour, which assists police in their response to young people, and which requires of them a commitment to cooperation with other points in the reporting system, is to be supported as a central component of a comprehensive strategy aimed at the goal of optimal quality of response.

The overall *Problem of Secondary Victimisation* appears to turn on the issue of achieving a reasoned and effective balance between what can be conflicting and complex demands. This problem can be resolved to the extent that police are clear that there is a broad based symmetry between humane treatment of the victim and effective investigation of the crime. It is in no-one's interests, other than those of the offender, to leave intact the public perception that the experience of reporting is at best a gamble and more frequently a metaphor for the rape itself. Delays in the provision of access to the Crisis Care Unit, premature taking of full statements either before provision of medical and emotional support or without an adequate opportunity to rest, inadequate provision of information, and judgemental attitudes do as much to imperil effective investigation as they do to undermine the humane care of the victim/survivor.

The evidence arising from this study suggests that appropriate support and information provision can be secured through adequate cooperation between the police, the forensic medical officers and the CASAs. None of these separate systems has any investment in the undermining of the course of justice. However, each must accept that justice is not served by processes that are inhumane to victim/survivors of sexual assault or by processes that work against a coordinated, multidisciplinary approach to full recognition of the victim/survivors' needs, rights and entitlements.

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APPENDIX A

COUNSELLOR/ADVOCATE ROLE DESCRIPTION

Within the protocol it is stipulated that the Counsellor/Advocate, on arrival at the Crisis Care Unit, spends a short period of time with the victim and remains available to the victim throughout her time at the Unit.

While at the Crisis Care Unit, the Counsellor/Advocate is required to carry out the following tasks:

- the provision of information regarding the role of the Counsellor/Advocate, other Crisis Care Unit personnel and activities that take place within the Unit;
 - the provision of information to the victim regarding relevant medical procedures and her rights and options in relation to these procedures;
 - the provision of information regarding the legal system, her options and rights;
 - the provision of support regarding emotional issues and concerns;
 - the provision of support and information to friends and family accompanying the victim to the Unit;
 - the organisation of a medical examination with Royal Women's Hospital Nursing staff, a Forensic Physician, a woman doctor on roster, or a Royal Women's Hospital registrar as required;
 - the co-ordination of medical staff and police personnel including Community Policing Squad and Criminal Investigation Bureau members attending the Unit;
 - as requested by the victim, being present throughout the medical examination in order to provide emotional support to the victim;
 - providing fresh clothing to the victim and assistance with showering as required;
 - ensuring prescription for the Morning After Pill and other medication is offered as required;
 - ensuring a medical certificate is offered to secure leave of absence from her place of employment;
 - organisation of a medical appointment for follow-up tests for pregnancy and sexually transmitted diseases;
 - organisation of emergency or supportive accommodation as required;
 - organisation of follow-up counselling support for the victim;
- and,
- where relevant, liaison with attending police regarding the taking of statements.

On average, the Counsellor/Advocate will spend three hours undertaking these tasks as part of the Crisis Care Unit service provision.

APPENDIX B

QUESTIONNAIRE AND DATA CODING SHEET

1. TIME
- 1 BH
- 2 AH

VICTIM/SURVIVOR DEMOGRAPHIC DATA

2. VICTIM/SURVIVOR RESIDENTIAL ADDRESS
- 1 Region 6
- 2 Region 7
- 3 Region 8
- 4 Rural
- 5 Other (Please Specify)
- 6 Unknown
3. GENDER OF VICTIM/SURVIVOR
- 1 Female
- 2 Male
4. AGE OF VICTIM/SURVIVOR
- 1 Under 15 years
- 2 15-20 years
- 3 21-30 years
- 4 31-40 years
- 5 Over 40 years
- 9 Unknown
5. SOCIO-ECONOMIC STATUS OF VICTIM/SURVIVOR
- 1 Student
- 2 Benefit
- 3 Home Duties
- 4 Non-Professional
- 6 No Income
- 9 Unknown
6. CULTURAL BACKGROUND OF VICTIM/SURVIVOR
- 1 English Speaking
- 2 Non-English Speaking
- 3 Aboriginal
- 4 Unknown
7. DISABILITY OF VICTIM/SURVIVOR
- 1 No Disability
- 2 Intellectual Disability
- 3 Psychiatric Disability
- 4 Physical Disability
- 9 Unknown
- (If more than one disability, please list)

ALLEGED OFFENDER DEMOGRAPHIC DATA

8. ALLEGED OFFENDER RESIDENTIAL ADDRESS
- 1 Region 6
- 2 Region 7
- 3 Region 8
- 4 Rural

- 5 Other (Please Specify)
- 9 Unknown

9. GENDER OF ALLEGED OFFENDER

- 1 Under 15
- 2 15-20 years
- 3 21-30 years
- 4 31-40 years
- 5 Over 40 years
- 9 Unknown

10. AGE OF ALLEGED OFFENDER

- 1 Under 15
- 2 15-20 years
- 3 21-30 years
- 4 31-40 years
- 5 Over 40 years
- 9 Unknown

11. SOCIO-ECONOMIC STATUS OF ALLEGED OFFENDER

- 1 Student
- 2 Benefit
- 3 Home Duties
- 4 Non-Professional
- 6 No Income
- 9 Unknown

12. CULTURAL BACKGROUND OF ALLEGED OFFENDER

- 1 English Speaking
- 2 Non-English Speaking
- 3 Aboriginal
- 9 Unknown

13. DISABILITY OF ALLEGED OFFENDER

- 1 No disability
- 2 Intellectual Disability
- 3 Psychiatric Disability
- 4 Physical Disability
- 9 Unknown
- (If more than one disability, please list)

ASSAULT DATA

14. NATURE OF ASSAULT

- 1 Rape
- 2 Attempted Rape
- 3 Indecent Assault
- 4 Aggravated Rape
- 9 Unknown

15. RELATIONSHIP TO OFFENDER

- 1 Stranger
- 2 Family Member

- 3 Friend/Acquaintance
- 4 Current/Ex-Partner
- 5 Multiple
- 6 Other (Please Specify)
- 9 Unknown

16. LOCATION OF ASSAULT

- 1 Public Place
- 2 Victim/Offender's Home
- 3 Other Home
- 4 Car
- 5 Work
- 9 Unknown

17. WAS THE ALLEGED OFFENDER UNDER THE INFLUENCE OF A SUBSTANCE AT THE TIME OF THE ASSAULT?

- 1 No
 - 2 Heroin/Methadone
 - 3 Alcohol
 - 4 Pills
 - 5 Marijuana
 - 6 Other (Please Specify)
 - 7 Unknown Substance
 - 9 Unknown
- If under the influence of more than one drug, please list)

18. WAS THE VICTIM/SURVIVOR UNDER THE INFLUENCE OF A SUBSTANCE AT THE TIME OF THE ASSAULT?

- 1 No
 - 2 Heroin/Methadone
 - 3 Alcohol
 - 4 Pills
 - 5 Marijuana
 - 6 Other (Please Specify)
 - 7 Unknown Substance
 - 9 Unknown
- If under the influence of more than one drug, please list)

REPORTING DATA

19. WAS THE ASSAULT BROUGHT TO THE ATTENTION OF THE POLICE?

- 1 Yes
- 2 No
- 9 Unknown

20. IF UNREPORTED, WHY? (RECORD ALL REASONS)

- 1 Offender known to, or feared by victim
- 2 Fear of police/legal process
- 3 Victim doesn't want family/friends to know
- 4 Other (Please Specify)
- 9 Unknown

IF UNREPORTED, THE QUESTIONNAIRE IS NOW COMPLETE

21. WHO REPORTED THE ASSAULT TO THE POLICE?

- 1 Victim
- 2 Other (Please Specify)
- 9 Unknown

22. DID THE POLICE ADVISE THE ROYAL WOMEN'S HOSPITAL OF PENDING ATTENDANCE AT THE CCU?

- 1 Yes
- 2 No
- 9 Unknown

23. APPROXIMATE TIME FROM REPORT TO ATTENDANCE AT THE CCU

- 1 Less than 1 hour
- 2 1-2 hours
- 3 2-3 hours
- 4 3-5 hours
- 5 More than 5 years
- 9 Unknown

24. IF MORE THAN 1 HOUR LAPPED BETWEEN TIME OF REPORT AND ATTENDANCE AT CCU, WHAT WAS THE REASON?

- 1 Statement, or lengthy preliminary statement, taken before attendance at CCU
- 2 CIB commencement of investigation
- 3 Other (Please Specify)
- 9 Unknown

25. APPROXIMATE TIME COUNSELLOR/ADVOCATE SPENT WITH VICTIM ON ARRIVAL AT CCU

- 1 15 minutes
- 2 More than 15 minutes
- 9 Unknown

26. IF THE COUNSELLOR/ADVOCATE SPENT MORE THAN 15 MINUTES WITH THE VICTIM/SURVIVOR ON ARRIVAL AT THE CCU, WHY?

- 1 Victim/Survivor ambivalent re: police involvement
- 2 Victim/Survivor confused about options
- 3 Other (Please Specify)
- 9 Unknown

27. BASED ON INFORMATION GIVEN TO THE VICTIM/SURVIVOR BY THE POLICE, PLEASE RATE THE VICTIM/SURVIVOR'S UNDERSTANDING OF ENSUING MEDICAL AND LEGAL PROCEDURES

- 1 Very good/clear understanding
- 2 Fair understanding
- 3 Minimal understanding/confusion
- 4 No information given
- 9 Unknown

28. APPROXIMATE TIME BETWEEN THE VICTIM/SURVIVOR'S ATTENDANCE AT THE CCU AND THE ARRIVAL OF THE FORENSIC PRACTITIONER

- 1 Forensic practitioner unable to attend
- 2 Up to 30 minutes
- 3 30 minutes to 1 hour
- 4 More than 1 hour
- 9 Unknown

29. IF MORE THAN ONE HOUR LAPSED BETWEEN THE VICTIM/SURVIVOR'S ATTENDANCE AT THE CCU AND THE ARRIVAL OF THE FORENSIC PRACTITIONER, WHAT WAS THE REASON?

- 1 Forensic practitioner attending another examination
- 2 Forensic practitioner not called within the hour
- 3 Other (Please Specify)
- 9 Unknown

30. WHAT FORM OF POLICE STATEMENT DID THE VICTIM/SURVIVOR MAKE OR INTEND TO MAKE ON LEAVING THE CCU?

- 1 No statement
- 2 Full statement
- 3 No further action statement
- 9 Unknown

31. IF NO STATEMENT OR NO FURTHER ACTION STATEMENT, LIST REASONS

32. WHEN WAS THE STATEMENT MADE?

- 1 Before medical examination
- 2 Directly after attending the CCU
- 3 After the victim/survivor was rested
- 4 Other (Please Specify)
- 9 Unknown

33. HOW CO-OPERATIVE AND RESPONSIVE WERE THE CPS TO THE VICTIM/SURVIVOR'S NEEDS?

- 1 Very responsive
 - 2 Responsive
 - 3 Not responsive
 - 4 Antagonistic
 - 9 Unknown
- Give example

34. HOW CO-OPERATIVE AND RESPONSIVE WERE THE CIB TO THE VICTIM/SURVIVOR'S NEEDS?

- 1 Very responsive
 - 2 Responsive
 - 3 Not Responsive
 - 4 Antagonistic
 - 9 Unknown
- Give example

35. ANY OTHER ISSUES RELATED TO POLICE ATTENDANCE?

APPENDIX C

MAP OF HEALTH DEPARTMENT VICTORIA REGIONS

REGIONS

1. Barwon-South Western
2. Central Highlands-Wimmera
3. Loddon-Campaspe-Mallee
4. Goulburn-North Eastern
5. Gippsland
6. Western Metropolitan
7. North Eastern Metropolitan
8. South Eastern Metropolitan

