Training Programme on Multisectoral Sexual Assault Interventions for Women

Participant Hand outs

This project is supported by the European Union Directorate-General Justice DAPHNE III Programme 2007-2013: *Combating violence towards children, adolescents and women* (Just/2010/DAP3/AG/1395)

NOTE

The following documents are part of the *Comparing Sexual Assault Interventions* (COSAI) 'Training Programme on Multisectoral Sexual Assault Interventions for Women'.

The documents should be used together with the Training Programme. This separate set of documents has been produced to facilitate the printing and distribution of material to the training participants.

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Module 1: Overview of the training

The following objectives and learning outcomes provide a clear indication of the goal and purpose of the training. Trainers can use these to focus the training and to assess the performance and success of participants. Participants can use them to evaluate the training from their own perspectives.

Goal

- To provide participants with the knowledge and tools to deliver multisectoral sexual assault interventions for women training

Objectives of the training

- To define what is sexual violence, its prevalence, causes and consequences
- To challenge the myths and stereotypes underpinning sexual violence
- To examine the factors that inhibit women disclosing and reporting
- To establish what is best practice for services in responding to victims of sexual violence
- To identify the policies that should be in place to enable best practice
- To examine the benefits and implementation of the COSAI Benchmarking and Evaluation Tool

Intended learning outcomes:

- An understanding of what is sexual violence, its prevalence, causes and impacts
- An awareness of myths and stereotypes underpinning sexual violence
- An understanding of the factors that inhibit women disclosing and reporting and what helps women feel supported and safe
- A commitment to best practice in the provision of front line sexual violence services
- A commitment to promote and implement the COSAI Benchmarking and Evaluation Tool
- An understanding of intersectoral and collaborative working to support and enable best practice

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Appendix 2a: Prevalence of sexual violence quiz

Questions

1 What percentage of women has experienced sexual violence by a partner in Europe?

(a) Below 10%
(b) 10-40%
(c) Above 40%

2 What percentage of sexual assault perpetrators are known to the victim in Europe?

(a) Below 25%
(b) 25-50%
(c) 51-75%
(d) Above 75%

3 From which age group are women usually found to be at more risk of sexual assault in Europe?

(a) 15-24 years of age
(b) 25-30
(c) 30-40
(d) 40 and older

4 What is the proportion of adult victims of serious sexual assault that report the incident to the police In Europe?

(a) Below 15%
(b) 15-30%
(c) Above 30%

5 What percentage of females are trafficked for the purpose of sexual exploitation in Europe

a) Below 25%
b) 25-50%
c) 51-75%
d) Above 75%

6 What percentage of women asylum seekers in the UK have experienced sexual violence?

(a) Below 25%
(b) 25-50%
(c) 51-75%
(d) Above 75%

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Appendix 2b: Prevalence of sexual violence quiz answers

Answers

Important: reliable data on sexual violence is scarce and not easily comparable between the EU Member States. However, the available sources quoted below provide an approximate overview of the extent of this problem in the European Union.

1 (b) For example, lifetime prevalence of intimate partner and/or non-partner sexual violence in the Czech Republic, was estimated at 35%, in Denmark at 28%, in Germany at 13% and in Poland at 17%.[1] In France the figure for sexual violence against adult women is reported to be 11%.[2] Survey data shows that almost 24% of Italian women had been victims of sexual violence[3] while the figure for Sweden is 34%.[4] A study in Ireland found that over 40% of women had experienced sexual abuse or sexual assault in their lifetime.[5] In England and Wales it is estimated that almost 20% of women has suffered a sexual assault since the age of 16.[6]

2 (c) The perpetrators of sexual assault are most often known to victims. A study of reported rape cases in 11 EU countries that shows that **two-thirds** of the victims knew their abuser.[7] In England and Wales over half of female victims were assaulted by partners or ex-partners. Fourteen percent were assaulted by strangers.[8]

3 (a) In England and Wales young women were at greatest risk of sexual assault with prevalence of past year victimisation rising to 7.9% in the 16-19 year old females.[9] A survey of the Baltic region countries identified a high percentage of young women who had been sexually abused by the age of 18 years: 42.5% in Estonia and 56.2% in Sweden reported having been touched in an indecent way. In the same study 10% of all young women aged 18 and under reported abusive sexual intercourse in all countries. [10]

4 (a) Sexual violence is known to be widely under reported to the police. Reported estimations on cases of rape range between 1-12% in Europe.[11] The lowest reporting rates of rape are found in Eastern and Southern Europe, while Sweden registers one of the highest reporting rates. In England and Wales it is estimated that 10% of adult victims of serious sexual assault report the incident to the police.

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[1] UN Women, *Violence against Women Prevalence Data: Surveys by Country*, compiled by UN Women as of March 2011:
www.endvawnow.org/uploads/browser/files/vaw_prevalence_matrix_15april_2011.pdf

[2] Crepaldi c et al., *Violence against women and the role of gender equality, social inclusion and health strategies*, *Synthesis Report*, for the European Commission, 2010, p. 75,:
http://ec.europa.eu/social/main.jsp?catId=750&langId=en&pubId=600&type=2&furtherPubs=yes

[3] Italian National Statistics Institute (ISTAT), *Survey on Violence against Women*, 2006

[4] Lundgren E et al., *Captured Queen, Men's violence against women in 'equal' Sweden- a prevalence study*, University of Uppsala, 2001:
http://www.brottsoffermyndigheten.se/Sidor/EPT/Bestallningar/PDF/Captured%20Queen%20.pdf

[5] McGee H et al, *The SAVI Report, Sexual Abuse and Violence in Ireland*, The Liffey Press and Dublin Rape Crisis Centre, 2002: http://www.drcc.ie/about/savi.pdf

[6] Office for National Statistics. Crime in England and Wales, quarterly first release to March 2012. London: Office for National Statistics, 2012

[7] Kelly L, Lowett J, *Different systems, similar outcomes? Tracking attrition in reported rape cases in eleven countries*, Child and Woman Abuse Studies Unit, 2009:
www.cwasu.org/publication_display.asp?pageid=PAPERS&type=1&pagekey=44

[8] Smith K, Coleman K, Eder S, et al. Homicides, firearm offences and intimate violence 2009/10: Supplementary volume 2 to Crime in England and Wales 2009/10. London: Home Office, 2011.

[9] Office for National Statistics. Crime in England and Wales, quarterly first release to March 2012. London: Office for National Statistics, 2012

[10] Mossige S et al. (eds.), *The Baltic Sea Regional Study on Adolescents' Sexuality*, NOVA, 2007:
http://www.nova.no/asset/2812/1/2812_1.pdf

[11] Crepaldi c et al., *Violence against women and the role of gender equality, social inclusion and health strategies*, *Synthesis Report*, for the European Commission, 2010, p. 75,:
http://ec.europa.eu/social/main.jsp?catId=750&langId=en&pubId=600&type=2&furtherPubs=yes

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5 (d) Victims of human trafficking subject to sexual exploitation are predominantly female (96 %) whereas the majority of victims of human trafficking subject to labour exploitation are male (77 %).[12] Trafficking in human beings is very much a gendered phenomenon.

6 (b) Forty eight percent of a sample of women seeking asylum in the UK surveyed for a report by Women For Refugee Women had been raped.[13] Rape, forced prostitution and other forms of sexual violence are one of the biggest risks women and girls face in conflict situations.[14]

[12] Eurostat *Trafficking in human beings* 2013: http://ec.europa.eu/dgs/home-affairs/what-is-new/news/news/2013/docs/20130415_thb_stats_report_en.pdf

[13] Dorling, K. Girma, M. And Walter, N (2012) *Refused: the experiences of women denied asylum in the UK* Women For Refugee Women

[14] United Nations, Human Rights. *Rape: Weapon of War* www.ohchr.org/en/newsevents/pages/rapeweaponwar.aspx

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Why does sexual violence against women happen?

Excuses men might make

Alcohol or drug dependency
Stress/poverty/oppression
He can't control himself
Mental illness
Testosterone
Sexual frustration
He misread the signals
She came to my house, she must have wanted sex
Women say 'no' when they mean 'yes'

Reasons why women might blame themselves

She led him on
She was making him jealous
She was drunk
She was wearing provocative clothing
She shouldn't have been walking home alone in the dark

Social conditioning

Macho expectations of what it is to be a 'real' man
Society allows men to think women are sexually available
He has no respect for women / thinks all women are slags / tarts (misogyny)
Society endorses sexual violence through pornography, sexualisation of women

Power and control

Because he thought he could get away with it
To teach her a lesson
'She's my girlfriend / wife, I can do what I like'
He likes to control women
Oppression of women through group behaviour (from shouting at women in the street to gang rape and murder)
Ineffective use of law
Lack of sanctions / law (in both civil society and in war situations)

All violence against women is not acceptable

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Module 4: Why women find it difficult to report sexual violence

Some factors that discourage and encourage reporting

Factors that discourage / prevent reporting	*Factors that encourage / support reporting*
• inadequate support systems • lack of faith in the police / courts • shame • fear or risk of retaliation by the perpetrator or the perpetrator's friends and family • fear or risk of being blamed • fear or risk of not being believed • fear or risk of being mistreated and/or socially ostracized • not naming rape as rape • not realizing that the assault is a crime • being drunk at the time of the attack • not wanting the perpetrator to be punished (for example, if it was a family member) • Being trapped within an abusive situation (for example, trafficking, forced prostitution)	• for personal protection • access to justice • encouraged by friends/ family • to prevent the man from attacking again (self or another woman) • availability of adequate services to help prevent sexually transmitted diseases and pregnancies. • availability of safe and confidential mechanisms or environments to report the assault.

This list is not intended to be an exhaustive list

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Module 5: The impact of sexual violence

The impact on women who have experienced sexual violence

Physical health symptoms

Studies show that less than half of sexual assault victims have any injury and only 22.8% have anogenital injury (injuries relating to the anus and genitals). Women are three times more likely to sustain a genital injury from an assault than consensual intercourse [15,16]

For post-pubertal girls who have not had intercourse before, penile vaginal penetration may occur without tearing the hymen. A hymenal laceration will heal within 2 weeks, without scarring, leaving a full thickness transection or deep notch (some hymen remains at base); after that time it is not possible to date the injury[17, 18]

Anal rape may cause fissures or deeper lacerations in the perianal skin but may also occur without persisting injury. [2, 19]

There may be physical signs that indicate possible sexual violence:[20, 21] It is helpful to categorise the physical health consequences of sexual assault in three ways: acute, medium term and long term.

Acute injury

Accurate forensic description of injuries may indicate the possible cause and therefore relate to the account of the assault and the subsequent legal process. It is important toconsider the sites and the severity of injury. Punches, kicks, throttling and firm grip may all cause distinctive types of injury. Stained and torn clothing should be sent for forensic analysis.

Physical findings following sexual assault may include:

[15] McLean I, Roberts S, White C, Paul S "Female genital injuries resulting from consensual and non-consensual vaginal injuries" 2011 Forensic Science International 204 (2011)

[16] Slaughter L, Brown RV, Crowley S & Peck R "Patterns of genital injury in female sexual assault victims" 1997 Am J Obstet Gynecol March

[17] Opinion on the significance of the genital and anal findings is referenced in 'The Physical Signs of Child Sexual Abuse' March 2008, Royal College of Paediatrics and Child Health

[18] 'Best evidence and clinical practice in obstetrics and gynaecology: clinical aspects of sexual violence.' 2013 Publisher: Elsevier

[19] McLean I, Balding V,White C "Forensic Medical Aspects of Male-on-Male Rape and Sexual Assault in Greater Manchester" 2004 Med Sci Law Vol 44, No 2

[20] The West Virginia Foundation for Rape Information and Services; West Virginia S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities, The effect of spousal violence on women's health: findings from the Stree Arogya Shodh in Goa, India. Chowdhary N, Patel V. J Postgrad Med. 2008 Oct-Dec; 54(4):306-12. Physical and sexual violence during pregnancy and after delivery: a prospective multistate study of women with or at risk for HIV infection.

[21] Koenig LJ, Whitaker DJ, Royce RA, Wilson TE, Ethier K, Fernandez MI. Am J Public Health. 2006 Jun;96(6):1052-9. Epub 2006 May 2.

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- Bruises: petechial (consisting of pinpoint haemorrhages), fingergrip pattern on arms and inner thighs; a yellow bruise is at least 18 hours old but, otherwise, it is not possible to date a bruise by its colour
- Abrasions and scratches (linear abrasions)
- Lacerations (tear of skin caused by blunt trauma), incisions (wound caused by sharp edge or blade)
- Bites, burns, fractures
- Bleeding from the vagina, (either from acute injury or menstrual) anus or an acute wound

If further medical or surgical treatment is needed (e.g. transfusion, suturing of vaginal/anal lacerations) forensic samples may need to be taken in theatre or accident and emergency department.

Medium term

- Unintended pregnancy - consider termination of pregnancy if lawful
- Care in continuing pregnancy
- Sexually transmitted infection including HIV/AIDS, hepatitis B as well as chlamydia, gonococcus, trichomonas vaginalis and syphilis.

Long term

- Problems in pregnancy - recurrent miscarriage, premature rupture of membranes
- Sexual difficulties including dyspareunia (painful intercourse), vaginismus (spasm of vaginal entrance muscles), disorders of desire, arousal and orgasm, aversion to sex
- HIV
- Pelvic Inflammatory Disease
- Chronic pelvic pain
- Infertility
- Irritable Bowel Syndrome, asthma, heart attack,
- Eating disorders
- Self harm

Mental health consequences

Acute trauma reactions

Acute trauma reactions are shock reactions, which can last from a few hours to a few days. They may also be delayed for one to three days and last from some days to four to six weeks. Acute trauma reactions are normal reactions to a traumatic event. The following behaviour/symptoms can occur simultaneously.

- Anxiety, panic, confusion
- Numbness
- Shock
- Memory gaps
- Impaired ability to think/function
- Distorted perception of time
- Depression, feelings of worthlessness
- Guilt, shame
- Dissociation

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- Depersonalisation, disorientation, out-of-body-experiences, hallucinatory experiences
- Amnesia

Long term symptoms (Post-traumatic Stress Disorder)

A person with PTSD will often relive the traumatic event through nightmares and flashbacks, and have feelings of isolation, irritability and guilt.

They may also have problems sleeping, such as insomnia, and may find concentrating difficult. The symptoms are often severe and persistent enough to have a significant impact on the person's day-to-day life.

The symptoms of PTSD usually develop during the first month after a person experiences a traumatic event. However, in a minority of cases (less than 15%), there may be a delay of months or even years before symptoms start to appear.

Some people with PTSD experience long periods when their symptoms are less noticeable. This is known as symptom remission. These periods are often followed by an increase in symptoms. Other people with PTSD have severe symptoms that are constant.

Re-experiencing is the most typical symptom of PTSD

A person will involuntarily and vividly relive the traumatic event in the form of flashbacks, nightmares or repetitive and distressing images or sensations. Being reminded of the traumatic event can evoke distressing memories and cause considerable anguish.

Avoidance

Trying to avoid being reminded of the traumatic event is another key symptom of PTSD.

Reminders can take the form of people, situations or circumstances that resemble or are associated with the event.

Many people with PTSD will try to push memories of the event out of their mind. They do not like thinking or talking about the event in detail.

Some people repeatedly ask themselves questions that prevent them from coming to terms with the event. For example, they may wonder why the event happened to them and whether it could have been prevented.

Hyperarousal (feeling 'on edge')

Someone with PTSD may be very anxious and find it difficult to relax. They may be constantly aware of threats and easily startled. This state of mind is known as hyperarousal.

Irritability, angry outbursts, sleeping problems and difficulty concentrating are also common.

Emotional numbing

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Some people with PTSD deal with their feelings by trying not to feel anything at all. This is known as emotional numbing. They may feel detached or isolated from others, or guilty.

Someone with PTSD can often seem deep in thought and withdrawn. They may also give up pursuing the activities that they used to enjoy.

Other possible symptoms of PTSD include[22]:

- Depression, anxiety and phobias
- Drug misuse or alcohol misuse
- Sweating, shaking, headaches, dizziness, chest pains and stomach upsets
- PTSD sometimes leads to the breakdown of relationships and causes work-related problems.

Providing care and support

Victims of sexual assault require comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The types of services that are needed include pregnancy testing, pregnancy prevention (i.e. emergency contraception), abortion services (where legal), STI testing and/or prophylaxis, treatment of injuries and psychosocial counselling.

It is important that healthcare workers work in partnership with other sectors. In addition to providing immediate health care, the health sector can act as an important referral point for other services that the victim may later need, for example, social welfare and legal aid. Health workers are also well placed to collect and document the evidence necessary for corroborating the circumstances of the assault, and for identifying the perpetrator and the health consequences of the event. Such evidence is often crucial to the prosecution of cases of sexual violence, where the woman chooses to report.[23] Information about Rape Crisis Centres, SARCs and similar organisations where available in other countries, must be made available in healthcare settings, particularly in women's toilets, as this may be the only place where women can access information without someone else (who may be the perpetrator) being present.

For further information, please consult the WHO Guidance to medico-legal care for victims of sexual violence.

[22] (Taken NHS Choices: Post-traumatic stress disorder – symptoms. http://www.nhs.uk/Conditions/Post-traumatic-stress-disorder/Pages/Symptoms.aspx)

[23] WHO (2003) Guidelines for medico-legal care for victims of sexual violence

Wider impacts of sexual violence on family and friends, the wider community and society

Family and friends

Sexual violence and rape can devastate the families of victims. Family member's responses can be crucial in supporting the victim. Families may want to help the victim, or if the sexual violence was perpetrated by a member of the family, there may be reluctance to discuss it, and the victim may feel she has brought 'shame' or 'disruption' on the family by disclosing. It can also be difficult for victims to carry on their normal routines for a time, such as working, housekeeping, caring for children so they may rely heavily on family members for that support. Male partners in particular may experience guilt at not being able to 'protect' their wife/partner from this assault and that somehow they have failed in their role. They may also need counselling and support.

Family and friends may not know how to handle the situation and avoid the victim. They may find the victim difficult to approach if she is exhibiting trauma symptoms as they are unprepared to understand or deal with this. They may have unrealistic ideas about how long it will take her to 'get over it' as most people have no idea of the complex issues that underpin this kind of trauma. They may ask the victim why she didn't fight back or report the attack to the police whilst not being aware that these are the most common things during assault-people shut down to try and mentally distance themselves from the trauma (disassociate) or to avoid violence. It may not always be possible to report, or the woman may not want to report to the police. The family members may also need some support themselves to be able to cope with their own feelings and reactions. Please see Rape Crisis advice on giving support: http://www.rapecrisis.org.uk/givingsupport2.php

Some useful tips are:

- give people a safe space to talk & then listen
- dont rush them, allow them time
- not to judge them or their choices (such as staying with the perpetrator in domestic cases)
- going with them to medical/legal appointments

Community

Although we know that most rape and sexual assault happens in the home, if it occurs in a public place it can create an environment of fear for all women in the area. There needs to be enough information provided by the authorities in the area to protect people but not enough to identify the offender or create a panic. The crime of sexual violence is not restricted to particular socio-economic groups or specific communities. Ultimately, the primary risk indicator is simply being female.[24]

Society

It is difficult to put a cost on the impacts of sexual violence, particularly as it will affect each woman in a different way. However, the array of services needed to deal with sexual assault, both in terms of victims and perpetrators, means there are

[24] UK Government (2011) Call to End Violence Against Women and Girls: Action Plan

implications and costs for a society as a whole. In Finland a study on physical and sexual violence or threats against women found the economic costs to society mounted to 48 million Euro (direct annual costs in the health sector 6,7 million Euro, in the social sector 14,8 million Euro and in law enforcement and criminal justice sector 26,6 million Euro). The Department of Health of England reported that each adult rape was to cost over £76 000 (close to 91 000 Euro) in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system. The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion (around €9.5 billion)[25].

[25] COSAI (2012) "Models of intervention for women who have been sexually assaulted in Europe: A review of the literature" Available at: www.cosai.eu

Module V: Case study on the impact of sexual violence

Case study: Sarah

Sarah is a 20-year-old trainee teacher.

Her mood has been very low since she split up with her boyfriend 3 months earlier; as a teenager, Sarah had been in various children's homes because of domestic violence within her family and she had learned to cope with anxiety by cutting her arms. This self-harm had restarted and she was not coping well with her college work.

Sarah was persuaded to go out with her college friends, who wanted to cheer her up, and they had visited various bars and clubs. Sarah was now very intoxicated and when they met up with three young men who bought them drinks and suggested that they all went to a party, Sarah and three other girls went to a nearby flat. Sarah's next memory is of waking in a bed, naked, with pain in her genital and anal area and she noticed blood on the sheet. The flat now appeared to be empty, so she found her clothing on the floor, dressed and asked a taxi driver to take her to the nearest police station.

Discuss in small groups:

1. What might Sarah's immediate concerns be?
2. What injuries might she have?
3. What forensic samples should be taken?
4. What are the issues to be addressed in the short and medium term?
5. What are possible long term consequences for Sarah?

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Case Study: Mary's story

One afternoon Mary was home getting ready to go pick up the children at school when her husband, David, came back unexpectedly. He came into the kitchen, smiled and told his wife he wanted to have sex. Mary refused because she had to go, but David threw her down on the floor and raped her.

Afterwards, Mary felt traumatised and betrayed and wondered if she should have seen it coming. In the early days of their relationship, when they met at university, David had seemed so charming. After a few months, Mary was in love with him. Only once, before they got engaged, had he threatened to slap her. When she started crying, he softened and said that he was sorry, he loved her and did not want to lose her.

Not long after that, they got married, despite the fact that Mary's mother thought that her outgoing daughter had become quiet and withdrawn. After Mary and David got married, all her friends gradually disappeared.

Questions for discussion:

- Which agencies might provide the help Mary needs?
- What would Mary's pathway to seek help look like in your local area/country?
- Can you identify any gaps or barriers for Mary accessing support?
- What can be improved to assist Mary in getting the help she needs?

Case study adapted from *New Philanthropy Capital: A Hard Knock on Life*

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Module 7: The COSAI Benchmarking & Evaluation Tool

Development of the Benchmarking & Evaluation tool (the Tool) has been based on the findings from research in the first phase of the *Comparing Sexual Assault Interventions* project: namely, a literature review[26] on models of intervention for sexual assault and existing evidence of service effectiveness; a mapping survey[27] gathering information on current policy and programming of services for sexual assault in European countries; and telephone interviews[28] with service providers on sexual assault service availability, effectiveness and appropriateness in different countries. This work found that the existing evidence does not provide commonly agreed indicators to measure effectiveness and accessibility to services. However, from the findings it was possible to identify a number of features of good/appropriate practices, which are recommended for policy makers and service providers to build into service design and provision. The tool has been designed in order to assess current practice against recommended aspects of service provision, to ensure comprehensive care and support, and more positive experiences for women who access sexual assault services.

The tool is not intended to be an international comparator. Instead, it is an instrument of self-reflection that seeks to assist services, or those commissioning them, to assess the way they work and plan changes according to the standards recommended.

The aim of the tool is to identify those mechanisms in each service and within the local setting, to address sexual assault. A set of benchmarks or standards against which service planning and provision can be assessed. The analysis will identify strengths and gaps in current service provision, which will assist services to complement and improve their practice and also plan and provide appropriate services for women who have experienced sexual assault.

The tool can be implemented for assessments at various levels: an individual service, all the services provided locally or the national situation in terms of sexual assault service provision and their standards and practices. Therefore, the tool can be used both by individual service providers and by national or local policy makers and commissioners who wish to review or design sexual assault service provision in their area.

The assessment questions are based on the multi-sectoral approach required to support and deal with the different short-, medium- and long-term care needs of women who have been sexually assaulted. These include:

1) Forensic services to collect evidence, if the woman wishes to pursue legal prosecution;
2) Medical services to treat injuries, potential pregnancy and STIs;
3) Psychosocial and practical services for mental health and well-being support (e.g. counselling, support groups, housing, child care); and
4) Criminal justice services to enforce the law and protect women's rights.

[26] www.cosai.eu
[27] Ibid
[28] Ibid

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The Tool is underpinned by a number of factors.

Firstly evidence suggests that there continue to be various myths and stigmas that influence perceptions of sexual assault by service providers, the general public and victims themselves, and that these can have negative effects on victims reporting and experience accessing services. The underlying principle of the COSAI project is to support the provision of services and interventions that recognise the rights and needs of women as the most important, in terms of access to respectful and sensitive services, guarantees of confidentiality and safety, and the ability to understand and determine a course of action for addressing all their care and support needs. In this regard, the findings from the evidence suggests that a specialized service for sexual assault, either in the form of a dedicated service or professional, will be better able to ensure care and reduce negative impact on victims.

Secondly, because of the multi-dimensional context that sexual assault support and care requires, coordination between sectors and services is also recommended.

Thirdly, the research also found that many countries have adopted national strategies and designed protocols to address sexual assault. While this may demonstrate political recognition of the problem, the mere existence of a strategy is not enough. It is imperative that they be implemented through specific actions, including those conferred to service providers from each sector.

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Module for practitioners I: asking appropriate questions

Scenario One

Health visitor: Jennie is 25 years old and has a six week old baby. This is a routine visit. Her partner is in the house when you call round.

Scenario one:
Jennie: You have been living with your partner for 2 years. When you first met he was very attentive and loving but in the past 18 months he has become very controlling and has been hitting you when you don't do as he says. He has also been forcing you to have sex when you don't want to. He doesn't like you going out on your own with the baby, even to see your Mum. He comes with you when you go to the shops and the baby clinic. Two nights ago he forced you to have sex with him even though you didn't want to and had told him you didn't feel ready after the baby was born.

Scenario Two

Mental health worker: Amanda has been referred to you by her GP (doctor). She has been diagnosed with depression and is self-harming by cutting her arms.

Scenario two:
Amanda: Six months ago you went for a drink with a colleague after work. Afterwards, you invited him in for a coffee, but once you were in your flat he tried to have sex with you. When you asked him to stop he said "I know you want it, otherwise why did you let me come in here?" Things got violent and he hit you in the face, and pushed you on the sofa and raped you. Since then, you have unable to go back to work. You went to your GP to get signed off work for a while, but he is a busy man, and you don't feel able to talk to him about what happened; you can only tell him you feel very low. He has given you anti-depressants, and as you have now been signed off work for some time, he has referred you to a mental health service.

Scenario Three

Housing advice service: Jean is a single parent with two small children. She has come to you to ask about being re-housed to a new area.

Scenario three:
Jean: You are separated from your husband, who had been violent to you during the relationship. He found a new girlfriend, and for some months he has not been in contact to see the children. Two weeks ago, he came around to the house in the evening, saying he and his girlfriend had split up, and he wanted to see the children. The children were in bed and you asked him to come back the next afternoon when they were home from school. He became very aggressive and said they were his children and that he could do as he liked. He said you were still his wife and he could still have sex with you when he wanted to. He then raped you on the living room floor. One of the children was crying and you are worried she may have heard what had happened. You are frightened of your husband, and are worried he will use contact with the children as a way of gaining access to your house and that he will rape you again.

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Module for practitioners II: responding to disclosure

Hand out 1

Factors that can escalate a crisis

ACCEPTANCE OF VICTIMISATION Failure to ask about suspicious injuries and emotional and/or behavioural indicators of sexual violence. Failure to react to her disclosure of sexual assault. Acceptance of intimidation as normal in relationships. Belief that abuse is a private matter in which we shouldn't interfere.	**VIOLATING CONFIDENTIALITY** Interviewing in front of family, colleagues. Telling colleagues (journalists, friends, neighbours, relatives, etc.) issues discussed in confidence without her consent.	**TRIVIALIZING AND UNDERESTIMATING TRAUMAS** Tolerance/ excusing perpetrator due to his drinking, stress, bad temper, inability to control men's sexual urges, etc. Not taking woman's feelings of danger. Superficial interviewing and medical check-up of victim.
IGNORING A NEED FOR SAFETY Failing recognize her sense of danger and fears for her future. Being unwilling to ask: "Do you have safe place to go? Do you have somebody to help you?"	**NOT RESPECTING HER** Trying to persuade her that it was not sexual assault. Not believing her.	**BLAMING THE VICTIM** Asking her what she did to provoke the perpetrator (for instance, dressing 'provocatively', going home very late alone, etc.). Asking her questions starting with 'why?'. For instance, "Why did you not report to the police? Why did it happen?". Taking the position that 'There are people who beat and who are beaten. There is nothing to do about it.'.

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Factors associated with providing comprehensive support

PROMOTE ACCESS TO COMMUNITY SERVICES (NGOs, public institutions) Knowing the resources in local community. Are there people/centres/telephone helpline she can talk to and where can she get advice, information, counselling or refuge?	**CONFIDENTIALITY** All discussions, interviews must occur in private, without other family members/friends/colleagues present. This is essential to building trust and ensuring her safety.	**BELIEVE & VALIDATE HER EXPERIENCES** Listen to her and believe her. Acknowledge her feelings and let her know she is not alone. Tell her that many women have similar experiences.
RESPECT HER NEED FOR FUTURE SAFETY Asking her what you can help to do to keep her safe. Does she have a safe place to go, can she talk to someone she trusts?	**RESPECT HER** Believing her that it was sexual assault. Telling her that her feelings about the incident are a normal reaction to traumatic experience.	**ACKNOWLEDGE THE INJUSTICE** The violence perpetrated against her is not her fault. No one deserves to be abused, it is always the responsibility of the perpetrator.

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Module for practitioners II: responding to disclosure

Hand out 2

Responding to disclosure

You do not 'have' to get a disclosure and never insist. Just asking gives permission for someone to talk when they are ready, and research shows that this is welcomed. Let her know that help is available if needed.

Make time for the victim to talk about what has happened at their own pace. An initial disclosure to you may be tentative because the victim fears your response and doesn't yet know whether it is safe to tell.

It may have taken a woman months or years to reach the point of disclosing her abuse, so how you respond is likely to make a difference about whether she is able to tell more and find help. Fear of being blamed or not being believed can stop her talking about her experiences.

Ask yourself if your intervention will leave the woman and any children she has in greater safety or greater danger. This requires the following good practice:

Good practice

- Ensuring the safety of the woman (and children) is of paramount concern. A woman is deemed to be 'safe' only when *she* feels she is.
- Respond empathically – women who have experienced sexual violence are often trying to make sense of a very disempowering and frightening situation. How you respond can, crucially, affect her choices to seek support and justice
- Acknowledge her courage in telling you about it. Asking for help is never easy, especially if you are feeling vulnerable and powerless, so an appropriate response is crucial on every occasion she makes contact, whether it is by phone or face to face.
- Reassure the victim that what happened was not okay, that you believe her and that she is not to blame.
- Don't blame or judge (i.e. "Why didn't you say anything sooner?" or "Why did you let him do it?")
- Don't question or criticise the information she gives you at the time of disclosure - even if the information seems implausible or if there are obvious errors. Remember that victims of trauma are sometimes unable to refer to accurate time frames or dates and should not be blamed or pressured when this does happen.
- Aim to empower the woman to make informed decisions and choices; give her time to consider the options that you present to her and try not to put pressure on her to do anything that she isn't ready to do.
- Respect confidentiality and privacy and recognise the real dangers that may be created if this is breached. Experience shows that perpetrators who are trying to track down women, or who discover a woman has disclosed abuse, are often very vindictive. Let her know in advance the limits to the level of confidentiality you can offer her (i.e. Safeguarding policies).
- To avoid endangering women who do not speak English (or the language of the service provider), only use professional interpreters - never ask partners, 'friends' or relatives to translate. The use of professional interpreters is imperative.

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Talking to others

- Inform the woman that she does not have to report to the police if she does not want to. Keeping records will be helpful if she does choose to report, either now or at a future date –see below.

- It is important to respect the woman's right to confidentiality while balancing this with the need to discuss their disclosure with relevant services (for example, safeguarding). Try to minimise re-telling by the victim - and consequently minimise her re-victimisation. Don't expect her to retell unnecessarily or demand it of her.

- If retelling is strictly necessary, gently explain to the victim that what she has said needs to be shared with another trusted professional. Explain that this is part of the process and it is one way in which you can help keep her safe.

- Explain to her that she has done the right thing in disclosing the assault. Tell her of other services that can help and support her, and that with her permission you can refer her to these. If she agrees, you can contact the police, and, if available, a SARC or Rape Crisis Centre or an ISVA (Independent Sexual Violence Adviser) who is best placed to support her throughout the process of gathering evidence, testimony, and providing medical treatment - as indicated by her wishes. Inform her of upcoming actions, her future options and other support resources you and your agency can provide.

Keeping written records

Accurately write down all that you will be expected to account for, particularly in relation to what the victim has told you, what you said, and time frames. This may be used as part of your statement, for reference, or as evidence in court. It also reassures the victim that you have heard her, that what she has said is important, and that you are taking the incident seriously.

Get professional feedback from a supervisor or manager.

You must not break the law (e.g. through dereliction of duty, negligent conduct, abuse, malpractice, assault on the victim - or by attacking the perpetrator). Not only would this make you liable for prosecution, but it can also work against any investigation that is conducted to help the victim.

Questions to ask on disclosure:

"Are you able to tell me a little bit more about what happened?"

"Was anyone else around?"

"Do you feel safe now?"

"Do you have a safe place to go?"

Do you want to report what happened to the police?

Do you want me to help you access a specialist support service for women who have experienced sexual violence?

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Victim blaming questions, which you should avoid:

Any question starting with "Why" (!!!) For instance:

"Why did you stay with him?"

"Why did you allow this to happen?"

"Did you provoke him?"

"Did you have a quarrel before he assaulted you?"

"Why didn't you tell anyone before now?"

Further resources are available at:

Sexual Offences Act 2003 on http://www.legislation.gov.uk/ukpga/2003/42/schedules

Care and Evidence DVD – available from www.careandevidence.org

The DVD provides two 10-15 minute videos on medical care and evidence collection following sexual assault, to support a further teaching session. Additional information and resources are available on the site.

http://www.thehavens.org.uk
www.rapecrisis.org.uk
http://www.stmaryscentre.org/
http://www.nhs.uk/livewell/abuse/pages/violence-and-sexual-assault.aspx[29]

[29] Some of this information has been adapted from: South Thames Foundation School and the Havens (March 2012) Sexual and Domestic Violence Teaching Resource Pack http://www.stfs.org.uk/faculty/training-about-sexual-and-domestic-violence)

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Module for practitioners II: responding to disclosure

Hand out 3: Case scenarios

Scenario one

Care worker: Margaret is 46 and has learning disabilities. She lives in supported accommodation. Margaret seems to like most of the staff and appears to be able to talk to them. When Margaret's brother comes to visit you notice she becomes very quiet and withdrawn. You want to talk with Margaret about this.

Scenario one

Margaret: You live in supported accommodation. You like most of the staff and feel able to talk to them. When your brother comes to visit he makes you masturbate him. This has been happening since you were a child. One of the staff members has noticed that you are quiet when your brother comes over and wants to ask you about it. Your brother has said that if you ever tell anyone he will be taken away by the police and it will be your fault. You don't want to get the blame for something like that.

Scenario two[30]

Doctor You are a junior doctor in A&E. Amy presents to A&E asking for emergency contraception. She is tearful and has brought a young child with her. Ask questions to find out why Amy is upset.

Scenario two

Amy: Last night your husband raped you while your 3 year old daughter was in the same room asleep. You recently came off the Pill and had been using condoms for contraception, but last night your husband didn't use one and you would like emergency contraception.

Scenario three

Doctor : You are a general practitioner. Susanna, aged 17, comes to see you with her husband, who looks at least 40. Susanna moved to the UK last year, but can speak little English. Her husband, who does all the talking, tells you that she is pregnant. Susanna makes no eye contact and looks thin and withdrawn.

Scenario three

Susanna: Your marriage was arranged for you against your wishes. Your husband does not let you out alone, or let you have any contact with your family. You have no friends in the UK. Your husband has sex with you against your wishes several times a week, and hits you if you refuse. You are pregnant but are frightened of having the baby. You are only allowed food if you have done all the housework for your mother-in-law, who also lives with you.

[30] Scenarios 2 and 3 taken from: South Thames Foundation School and the Havens (March 2012) Sexual and Domestic Violence Teaching Resource Pack http://www.stfs.org.uk/faculty/training-about-sexual-and-domestic-violence)

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Module for policy makers/service leads

Hand out 1

Collaborative and integrated working

The diagram highlights the developmental nature of collaborative and intersectoral working. There may be situations where it is sufficient for agencies to operate independently but exchange information. However, to achieve a more integrated approach to service delivery will require a different way of planning, sharing of information and a shift in culture.

Stakeholders wishing to engage in a collaboration should always keep in mind the principle of **collaborative gain**: there should be clear client or service benefits that arise from the efforts of agencies/departments to work together.

<table>
<tr><th colspan="4">Stage/level of collaboration</th></tr>
<tr><td>1</td><td>2</td><td>3</td><td>4</td></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="2"></td><td>Integrated working for collaborative gain: jointly planned with client and organisational benefits.</td></tr>
<tr><td>Some joint working: opportunistic, but not systematic.</td><td rowspan="2"></td></tr>
<tr><td>Information exchange between departments or organisations.</td><td></td></tr>
<tr><td>‘Department’ only; separate ‘silo’ working.</td><td colspan="3"></td></tr>
</table>

Module for policy makers/service leads

Hand out 2

Collaboration assessment questionnaire

On a scale of 0 – 10, identify individually how well you think your collaboration arrangements are against these characteristics. Discuss in groups your assessments and the reasons behind them. Based on your assessments identify those areas that need to be developed further.

		Not at all										Always works well
Characteristic		0	1	2	3	4	5	6	7	8	9	10
1	**Leadership: senior managers expect and encourage commitment to collaborative working.**											
2	**There are clear goals for improving collaborative working, involving all stakeholders.**											
3	**There are clear governance arrangements in place for planning and reviewing collaborative performance.**											
4	**Each partner agency knows what its contribution to achieving service improvement is.**											
5	**Partner agencies communicate with one another effectively.**											
6	**Mechanisms are in place for the appropriate sharing of information.**											
7	**Partnership arrangements work at strategic and operational levels.**											

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8	**Mutual respect between all partners is evident in all service processes.**											
9	**Partner agencies trust one another.**											
10	**There is a culture of shared learning in place.**											

Module for policy makers/service leads

Hand out 3

Four Square Matrix Analysis Charts- Collaborative working: where are you now?

These matrix charts are helpful in identifying the strengths and weaknesses of current relationships between agencies. They can be quite challenging to use as they require a high degree of honesty. For this reason they can also be used within an agency as an initial starting point for identifying where efforts need to be made to improve partnership working. In all cases the desired position is for relationships to be located in the top right quadrant.

Trust		
High	Opponents	Allies
Low	Adversaries	Bedfellows
	Low	High
	Goal agreement	

Challenge		
High	Defensiveness	Learning
Low	Static	Cosy
	Low	High
	Support	

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Commitment		
High	Spectator	Winners
Low	‘Zombies’	Terminal cynics
	Low	High
	Energy	

Assertive		
High	Selfish, chaotic	Productive
Low	Unproductive zombies	Stagnant bedfellows
	Low	High
	Cooperative	

Module for policy makers/service leads

Hand out 4

Strategy map

Strategy mapping is a performance system for translating strategic intent into the critical few actions that are required to achieve high-level goals. The important point is to demonstrate the cause and effect linkages between the actions at different levels. There are likely to be more action points at the lower levels. Each action point should be subject also to a performance measure. The technique can be used for a multi-sectoral service or for an agency's contribution to a shared key result and goal, with some shared actions.

Key result	A decrease in the social, mental and health harm to women victims of sexual assault.
Organisational goal	Improved effectiveness, appropriateness and humanity of sexual assault-related services.

Client service wants *(How do key results and organizational goals translate into what clients are looking for: public service users; service commissioners, partner agencies)*	1.	2.	3.

Organisational processes *(Systems and procedures needed to achieve service wants)*	

Learning and growth *(Skills & knowledge that staff need to have to implement systems and procedures well)*	

Resources *(Levels and changes to investments and budget allocations required)*	

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