Not worth reporting: women’s experiences of alcohol, drugs and sexual violence

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The world is a busy place, and many of us are managing competing demands on our time. As such, we are extremely grateful to the survivors who took the time to share their experiences with us. With your words, we hope to be able to make positive changes to the level of support and justice that survivors of sexual violence receive.

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Executive summary

Dominant narratives around the links between sexual violence and alcohol or other drug use are often problematic, if not outright victim-blaming. This includes public awareness campaigns that seek to limit women’s freedom of movement and expression through advice to limit drinking or take taxis home from bars, through to jury attitudes that result in women being seen as less ‘reliable’ witnesses in court if they were intoxicated at the time of the offence. Nevertheless, it seems clear that perpetrators are often predatory and do target vulnerabilities, with a third of survivors who report being raped to the Metropolitan Police Service also reporting that they had taken substances prior to the attack, and one in six reporting having a mental health problem (Stanko, 2011).

While it is an offence under the Sexual Offences Act 2003 to administer a substance with the intent of incapacitating someone in order to sexually assault them, the law is less clear when survivors have knowingly consumed drugs and/or alcohol. The prosecution must demonstrate that the survivor lacked ‘capacity to consent’ through intoxication, and while judgements have suggested that the law provides clear guidance on capacity (R v Bree [2007] EWCA 256), survivors who were intoxicated at the time they were raped continue to face being labelled as unreliable witnesses, both by the Crown Prosecution Service (CPS), jurors (Wenger & Bornstein, 2006) and the public (Opinion Matters, 2007; ICM, 2005).

AVA’s primary purpose in undertaking this research project was to seek the views of survivors themselves on this sensitive topic, and in particular, to investigate the relevance of the concept of “capacity to consent” to survivors. In order to achieve this, we employed a mixed methods approach, comprising:

a. A literature review investigating how the use of alcohol or other drugs is understood to impact on “capacity to consent” to sexual activity.

b. Two online questionnaires. One questionnaire was targeted at practitioners working with survivors of sexual violence, to which 123 people completed more than the initial eligibility questions. The second survey was targeted at survivors of sexual violence to ascertain whether either they or the perpetrator had consumed alcohol or other drugs prior to the assault. 167 people responded to the survivor questionnaire, and the answers from 76 respondents were used in the analysis. Other respondents were either ineligible or only completed the demographic questions.

c. One-to-one interviews. 21 survey respondents provided contact details, of which six participated in an interview with a researcher.

Key findings:

- Of all the findings, the most striking was that out of 76 respondents, 57% had survived more than one drug-facilitated sexual assault (DFSA) and 17% reported surviving ten or more such assaults.

- Alcohol is the most commonly consumed substance. 97% of respondents had consumed alcohol. Other substances consumed included cannabis (13%), benzodiazepines (8%) and cocaine powder (5%). One respondent reported having taken ecstasy, one reported having taken amphetamine and one reported having used crack cocaine and heroin.

- Most survivors (80%) had consumed substances of their own free will. Five respondents who had chosen to consume substances also reported that they consumed substances under
pressure or coercion, and four stated that as well as consuming by choice they also consumed unknowingly. A small minority (12%) reported that they believed that they had, or may have had their drink spiked.

- Survivors most commonly reported impacts on motor control (feeling dizzy, falling over) and that they kept falling asleep. 12% of survivors reported being unconscious at some point during the attack, with a further 42% reporting that they could not move, they kept blacking out or falling asleep, that they could not speak, or a combination of these effects. Amongst these survivors, six respondents also described having gaps in their memory.

- Almost half of survivors (47%) believed they were probably or definitely still physically capable of communicating consent (but that they did not give this consent), 12% stated that it was possible that they were unable to communicate consent, and 41% stated they were probably or definitely unable to communicate consent.

- Importantly, there was a clear relationship between some effects of substances (split into two ‘clusters’) and survivors’ perceptions of whether they had the ability to communicate consent. Cluster one symptoms, i.e. being unconscious, blacking out, having no memory of what happened, not being able to move or speak, feeling confused, vomiting and falling asleep were associated with a belief that the survivor was probably or definitely unable to communicate consent at the time of the assault. Conversely, experiencing cluster two symptoms of feeling physically sensitive to touch, feeling anxious or panicky and having no sense of time were associated with believing that the survivor was probably or definitely able to communicate their consent at the time they were attacked.

- Most survivors (75%) rejected the suggestion that it was only at the point of losing consciousness that a person loses their ability to consent to sex. Rather, survivors understood that a lack of capacity to consent depends on the level of intoxication, which will vary from person to person.

- 32% of the respondents did not tell anyone about the assault. Of those who did tell, 57% spoke to family and friends.

- Overall, 19% of survivors had reported to the police. Among those who did report to the police, 54% had a negative or very negative experience, 23% said their experience was neutral, and 8% had a very positive experience.

- When asked how drugs or alcohol consumption impacted on the police treatment of them, 47% (n=6) said that they believed it had impacted negatively or very negatively.

- When professionals were asked “how seriously do you think police take cases of sexual assault where the survivor was intentionally intoxicated, in comparison to other assault cases”, 37% said that it would be taken much less seriously and 33% said slightly less seriously. 70% also believed a conviction would be slightly or much less likely.

- Overwhelmingly, survivor survey respondents felt that, if the victim or survivor of an assault had drunk alcohol or taken drugs prior to an assault they would be less likely to be believed or supported by others.

- When asked how critical other people would be of the perpetrator when they had consumed alcohol, 34% of respondents said that it would make no difference as to how critical they would be of the perpetrator’s actions but 32% said that it would make others less critical of the perpetrators actions.
• Almost half (44%) of the respondents reported decreased substance use. 33% said that it had stayed the same and 25% said that it had increased.

• What was most strongly communicated through this research is that victims and survivors who consumed substances before the assault frequently face even greater barriers to achieving justice than survivors who had not been drinking or taken drugs. They also experience additional stigma and disbelief about the harm they have experienced if substances were consumed prior to them being sexually assaulted or raped.

Our recommendations include:

• Further consultation should be conducted with survivors and professionals on a symptom-based or ‘cluster’ approach to ascertaining capacity to consent in relation to intoxication to inform a structured model and clear guidance for professionals throughout the criminal justice system.

• Further research to explore the extent to which the symptoms-based approach is already being used and could be further utilised in investigating, prosecuting and legislating against violent crime is required.

• Training for police officers on using the symptoms-based approach when investigating reports of drug-facilitated sexual assault.

• Extension of the Crown Prosecution Service Guidelines on Prosecuting Child Sexual Abuse cases (2013) to adults for its recognition that if “the victim has been, or is, abusing drink or drugs” or their account they give in “inconsistent”, this should be understood as a possible indicator that abuse has taken place rather than undermining the victim’s credibility.

• Review judicial directives given to juries on rape and sexual assault cases should include a direction which relates to rape myths connected to substance use.

• Increased and easier access to specialist sexual violence services, Sexual Assault Referral Centres (SARCs), Independent Sexual Violence Advisors (ISVA’s) and sexual violence counselling services.

• Research to collate survivor views on ‘consent’ with an aim to provide effective educational resources and public awareness campaigns.

• Police prevention campaigns relating to sexual offences and alcohol to be informed by survivor views and to focus messages on perpetrator behaviour rather than on victim responsibility.
Introduction

AVA (Against Violence & Abuse) is a national second-tier charity working to end violence against women and girls. AVA’s Stella Project was set up in 2002 to address gaps in service provision for survivors and perpetrators of domestic violence who use substances problematically, and in 2010 expanded its remit to include improving responses to survivors of sexual violence who have problems with alcohol or other drug use, as well as to survivors of violence against women who have mental health problems.

Dominant narratives around the links between sexual violence and alcohol or other drug use are often problematic, if not outright victim-blaming. This includes public awareness campaigns that seek to limit women’s freedom of movement and expression through advice to limit drinking or take taxis home from bars, through to jury attitudes that result in women being seen as less ‘reliable’ witnesses in court if they were intoxicated at the time of the offence. Nevertheless, it seems clear that perpetrators are often predatory and do target vulnerabilities, with a third of survivors who report being raped to the Metropolitan Police Service also reporting that they had taken substances prior to the attack, and one in six reporting having a mental health problem (Stanko, 2011).

While it is an offence under the Sexual Offences Act 2003 to administer a substance with the intent of incapacitating someone in order to sexually assault them, the law is less clear when survivors have knowingly consumed drugs and/or alcohol. The prosecution must demonstrate that the survivor lacked ‘capacity to consent’ through intoxication, and while judgements have suggested that the law provides clear guidance on capacity (R v Bree [2007] EWCA 256), survivors who were intoxicated at the time they were raped continue to face being labelled as unreliable witnesses, both by the Crown Prosecution Service (CPS), jurors (Wenger & Bornstein, 2006) and the public (Opinion Matters, 2007; ICM, 2005).

AVA’s primary purpose in undertaking this research project was to seek the views of survivors themselves on this sensitive topic, and in particular, to investigate the relevance of the concept of “capacity to consent” to survivors. As a second-tier charity, our intent was to ensure that any guidance for policymakers, practitioners and other professionals that we produce on this issue is shaped by the views and experiences of survivors of sexual violence. We hope the words of survivors shared in this report will serve to challenge the very prevalent blaming of victim/survivors who have used substances prior to being raped or sexually assaulted and make visible the predatory behaviour of sexual violence perpetrators.
Aims and methodology

1. Aims

This research project aimed to:

1. Review existing evidence on survivors’ substance use prior to sexual assault, and how this is deemed to impact on their “capacity to consent” in UK law
2. Seek the views of survivors of sexual violence about how they believe their use of alcohol or other drugs impacted on their capacity to consent, including how this impacts on their involvement (or not) with the criminal justice system
3. Highlight similarities and differences between survivors’ views on capacity to consent, and medical and legal definitions in the UK
4. Contribute to an evidence base for AVA to produce guidance for policymakers and professionals, including police and prosecutors, on promoting access to justice for survivors of sexual violence who use substances.

2. Methodology

The research design took a mixed methods approach, including a literature review, online questionnaires and one-to-one interviews.

2.1 Literature review

The researchers used a Rapid Evidence Assessment\(^1\) with one overarching question and four specific questions. Our overarching question was:

2. How is the use of alcohol or other drugs understood to impact on “capacity to consent” to sexual activity?

The four specific questions were:

1. In relation to intoxication, how is “capacity to consent” to sexual activity defined in UK law?
2. What are the medical understandings of the incapacitating effects of alcohol and other drugs on the body?
3. What do sexual violence professionals believe about intoxication and “capacity to consent”?\(^2\)
4. Is there any existing literature which considers survivors definitions of “capacity to consent” in relation to intoxication? If so, what are the conclusions?

Information on databases searched is available in Appendix 1.

2.2 Online questionnaires

Two online questionnaires were designed, based on the findings from the literature review. One online questionnaire was targeted at practitioners working with survivors of sexual violence, whilst the other was targeted at survivors of sexual violence to ascertain whether either they or the perpetrator had consumed alcohol or other drugs prior to the assault. We asked similar questions

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of survivors and professionals throughout, in order to allow us to compare responses between the two groups. These questionnaires are available in Appendices 2 and 3.

The questionnaires were made available on the SurveyMonkey website from 16 April 2012 to 20 May 2012 inclusive and invitations to participate were circulated through AVA’s networks (primarily service providers) and in other organisation’s newsletters, on Twitter and through online forums. This recruitment strategy was chosen due to resource limitations and the resulting self-selected sample cannot be considered representative of all sexual violence survivors, since it was more likely to have reached literate survivors with access to the internet, as well as survivors who are either engaged with services or involved in campaigning around sexual violence.

One hundred and sixty-seven people responded to the survivor questionnaire, 95 of whom were eligible to participate in the research and consented to participate. The eligibility criteria were that: (a) the respondent was at least 16 years old; (b) they had been sexually assaulted since they turned 16 in an incident where either they or the perpetrator had taken alcohol or other drugs prior to the attack; and (c) that either the assault or the criminal justice process happened in England or Wales. Of these 95 eligible respondents, only 77 respondents answered further questions following the eligibility questions, one of whom then only answered demographic questions. Analysis was only conducted on answers provided by the 76 respondents who consented to participate and were both eligible to participate and answered questions other than eligibility and demographic questions.

In terms of the sample of respondents to the survivor questionnaire, the following demographic points are noted:

- Lesbian, gay & bisexual (LGB) people are estimated to make up between 5% and 7% of the population (DTI, 2003), however only 49 (64.5%) respondents in our sample identified as heterosexual. In total, 19.7% identified as bisexual, 6.6% as lesbian or gay and four respondents as queer, pansexual or asexual. Three respondents preferred not to disclose their sexual orientation.
- 65 (85.5%) respondents identified themselves as White British. Although this is broadly representative of the population, the small number of Black and Minority Ethnic (BME) women respondents means that the specific experiences of these women, including intersections between sexism and racism, are likely to be less visible in the data.
- 12 (15.8%) of respondents identified themselves as disabled, which is slightly lower than the estimated prevalence in the general population of 19% (DWP, 2012).
- Only one woman over 55 responded, with the median age of respondents being 33 years old. The majority of respondents (65%) were between 25 and 45 years old inclusive.
- As a whole, the research findings reflect the particular experiences of the individuals that completed the survey namely 75 women, including one trans woman, and one man.

Further, only 15 respondents (19.7%) to the survivor questionnaire reported use of any illicit substances in the hours before they were attacked; three reported having used cocaine powder and just one reported having used heroin and crack cocaine. This compared with 35% of professionals who reported that survivors they work with have often or always consumed either cocaine powder, crack or heroin in the hours before they were attacked. Prevalence in the survivor questionnaire is twice as high as past year illicit drug use in the general population (8.9%) (HO, 2012), however the much higher prevalence reported by professionals may reflective of the fact that 50% of professional respondents provide substance misuse services and so are
disproportionately likely to have contact with survivors who are using Class A drugs. For this reason, the responses of professionals are likely to be skewed towards the experiences of dependent, Class A drug users, compared to the survivor survey which is more likely to represent experiences of alcohol and drug users who may or may not be dependent.

Two hundred and forty-seven people responded to the professional questionnaire, 123 of whom consented and went on to answer questions other than initial eligibility questions. To be eligible to participate in the research, professionals had to be working in England or Wales and be working with adults.

The data generated was analysed using Excel spreadsheets.

2.3 Semi-structured interviews
Survivor questionnaire respondents were asked whether they would be willing to also participate in a focus group, with 21 respondents providing their contact details for this purpose.

Whilst the original research design included focus groups to be conducted with these survivors, the researchers made an ethical decision to amend the research design to make these individual, semi-structured interviews. This decision was taken following review of questionnaire responses, taking into account the diversity of survivors’ views about this very sensitive issue and concerns to ensure that all research participants felt safe and supported throughout. The researchers also felt that individual interviews would provide greater opportunity for women to discuss their own thoughts, ideas and experiences as freely and in much detail as they wished.

Of the 21 participants who provided contact details, six confirmed an interview time and participated in an interview with a researcher. Three interviewees attended face-to-face interviews at AVA’s offices in London and the remaining three interviewees participated in interviews over Skype or via phone.

The semi-structured interview questions built on the responses survivors had given to the questionnaire; see Appendix 4 for a copy of the interview schedule.

The interviews were transcribed and coded to identify common themes.

2.4 Ethics
Understanding the potentially distressing nature of the subject matter, everyone completing the survey for survivors and participating in the interviews were asked to give consent to participate, having been advised of the purpose of the research, the types of questions that would be asked and warned that they will be asked to reflect to experiences of sexual violence. The survey introduction contained the following information:

“Please note that it is not essential to answer all of the questions and you may stop the survey at any time. This survey may be particularly distressing for recent survivors of sexual assault or those suffering from symptoms of traumatic stress (anxiety, lack of sleep, depression, difficulty in social situations etc). Please do not attempt this survey if you think that engaging with your experiences may prompt flashbacks or distress.”
On each page of the survey, contact details for the national Rape and Sexual Abuse Support Helpline and the Samaritans were provided in case the respondent needed to talk to someone as a result of completing the survey. Similar information was provided for the interviewees.

Survey respondents and interviews were advised that all information collected would remain confidential, be stored securely and would only be used anonymously for the purposes of this report.
Literature review

The law on sexual consent in England and Wales is governed by the Sexual Offences Act 2003, legislation developed in consultation with women’s organisations with the aim of addressing low conviction rates for sexual offences. What follows is an explanation of the law in relation to intoxication and capacity to consent to sexual activity as it currently stands and a review of critiques in the literature of the application of the law, alongside a review of the literature from the sexual violence and drug and alcohol fields about relationships between substance use, capacity and sexual violence.

1. The law on intoxication and ‘capacity to consent’

Under Labour, the Government’s primary focus on defining consent in the Sexual Offences Act was on age and mental capacity rather than intoxication (Gunby et al, 2010). In section 74 of the Act, “consent” is defined as “an agreement by choice, by a person who has the freedom and capacity to make that choice”, moving away from a definition of consent as being a simple “yes” or “no”. Section 75 sets out specific situations in which it will be presumed that the victim did not consent, unless the defendant is able to cast doubt on the presumption and argue that consent should be determined by the jury. Most notably, if the victim was asleep or unconscious at the time of the sexual assault, or if someone has administered to the victim, without the victim’s consent, a substance which enabled the victim to be overpowered at the time of the sexual assault, it is up to the perpetrator to prove that the survivor consented. As a result, it’s clear that these presumptions would only apply in the specific situations when a victim was either unconscious, or in cases of drink spiking. No mention was made in the 2003 Act of a situation in which a survivor had voluntarily consumed substances and was intoxicated, but was not unconscious.

It is noteworthy that unlike the Sexual Offences Act, the UK Advisory Council on the Misuse of Drugs (ACMD) does not distinguish between covert, forced and voluntary consumption of substances in its definition of drug-facilitated sexual assault (DFSA) (2007:5). Further, despite the prevalence of media stories about so-called “date rape” drugs such as Rohypnol, research consistently demonstrates that alcohol is the drug most commonly implicated in DFSA (EMCDDA, 2008:6; Papadodima et al, 2007; Lovett and Hovarth, 2009). In one study of toxicological tests taken in cases of DFSA in the United Kingdom between 2000 and 2002, alcohol was the most common (46%) followed by cannabis (26%), cocaine (11%) and then in smaller quantities benzodiazepines (e.g. Rohypnol), non-sedative antidepressants, ecstasy and Gamma-hydroxybutyrate (GHB) (Scott-Ham & Burton, 2005).

The case of R v. Bree in 2007 dealt in more detail with the relationship between intoxication and consent. In this case, the victim had been out drinking with a group of friends and when she returned to the place where she had been staying, she went to the bathroom where she lay on the bathroom floor vomiting. She maintained that she awoke to find Benjamin Bree raping her, and that she was saying no in her head but that she was too drunk to be able to physically resist (Cowan, 2008:913). Bree was convicted, but appealed on the basis that during the trial, intoxication had only been mentioned in the context of the survivor’s reliability as a witness, rather than to discuss its relationship to her consent to sexual activity (Rumney & Fenton, 2008:281). In the judgement quashing Bree’s conviction, the Court of Appeal judge, Lord Judge, suggested that the Sexual Offences Act of 2003 was coming from the “common sense” starting point that a woman who was

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unconscious was unable to consent to sexual activity. Beyond that, he reiterated that the law did not consider a further relationship between intoxication and sexual consent. Lord Judge noted that in English society, there was nothing unusual about sexual activity occurring when one or more of the participants were heavily intoxicated. He proceeded to consider the concept of intent and noted that drunken intent was still considered to be intent. Similarly, he conceded that drunken consent was still considered to be consent. He suggested that the instructions given to the jury by the judge should have been to define what consent was and to consider the case under the principle that the person did not consent rather than that she was unable to consent. While Lord Judge did state that a person would reach the point where she would be unable to consent before she lost consciousness, he indicated that it would be approximately around the point when she was physically unable to consent. He did not provide a specific objective example of how to evaluate when the person in question would have lost her capacity to consent.

1.1 Critiques of the Court of Appeal’s judgement in R v Bree

In criticism of the Court of Appeal’s judgement in R v Bree, Jesse Elvin (2008) notes several oversights in the consideration of the 2003 Sexual Offences Act. The first was that section 75(2)(f) only considers situations where a substance was administered without the consent of the victim. Elvin expresses concern that it ignores situations in which the victim was pressured into consuming more alcohol. His second objection is the attitude of Lord Judge stating that “drunken consent is still consent” and the Lord Judge’s concern that holding otherwise would limit the sexual autonomy of those who were intoxicated. Elvin argues that the Court of Appeal had focused too much on ensuring sexual autonomy without considering the extent to which sexual autonomy could be negatively interfered with. Phillip Rumney and Rachel Felton also note that the Court of Appeal judgement gave minimal direction as to what alternative directions the judge should have given to the jury and made no suggestions as to what appropriate directions would be. Yet they remark on the positive tone of the judgement: the Court of Appeal was at pains to note that both parties were free to choose how much to drink and to have intercourse if they wished, stating indeed that “there is nothing abnormal, surprising, or even unusual about men and women having consensual intercourse when one, or other, or both have voluntarily consumed a great deal of alcohol.” The Court of Appeal then proceeded to point out that “it is not a question whether either or both was behaving irresponsibly” (Rumney & Fenton, 2008:283). Like Elvin, Rumney and Fenton argue that the Court of Appeal was not focused enough in considering the possibility of negative interference in sexual autonomy.

Shlomit Wallerstein (2009) goes further still, recommending that the law be amended so as to not consider drunken consent to still be valid consent. She states that she believes the law should be amended so as not to recognise this consent. Wallerstein looked at the principle stated by the Court of Appeal that since “drunken intent is still intent”, “drunken consent is still consent” and suggests that it is a bit contradictory that this logic of intention is being applied to a victim of a crime, rather than a perpetrator (2009:326). She suggests the roots of this decision lie in a strong culture of victim blaming:

Further, viewing an act of getting drunk as an indirect choice to have sexual intercourse amounts to saying that whenever women choose to get drunk, they also implicitly consent to intercourse. As a matter of reality, this is, of course, untrue. It has a touch of prejudice of the kind recognised in statements like ‘she was asking for it’, which are made against women dressed in ways that might be considered provocative (Wallerstein, 2009:327).
Wallerstein suggests that instead of consent being valid until the exceptions in section 75, there should be a much lower threshold. She admits that the practicality of this law would be difficult, as it is impractical to come up with an objective point at which consent would be considered invalid and suggests that a more practical solution would be to consider if consent was given before intoxication. Wallerstein believes that consent could be implied throughout all the relevant facts, including a previous relationship. Specifically, her idea is that the law should be changed so that it is unreasonable to believe that an intoxicated person has consented, but would allow for when a perpetrator has mistaken someone’s level of intoxication (341). Wallerstein suggests that this would help to increase rape convictions, on the basis that jurors have been shown to be unable to use their own “common sense” and could use more of a legal guideline (343).

Sharon Cowan also discusses this case as evidence that the Act does not sufficiently protect women (2008:904), arguing that cases such as R v Bree result in a situation where if a woman cannot remember refusing to have sex, or if she cannot remember anything, then as long as she was still conscious she will be presumed to have consented (914). Cowan argues:

While on the one hand it is clearly unfair to convict someone of an offence they have not committed, on the other, it is similarly egregious to leave uncontested the notion that someone who is drunk enough to have memory blackouts and be vomiting, with periods of unconsciousness, can be presumed to have the capacity to consent (914-15).

Cowan suggests two possible amendments to the Sexual Offences Act: including “extreme drunkenness” as a rebuttable presumption of lack of consent under Section 75 of the Act (909), or inserting provisions that make clear that “when capacity through intoxication is in doubt, it is irrelevant how that intoxication came about” (910). Cowan also suggests a cluster of symptoms, such as “vomiting, inability to speak or move, memory loss, or periods of unconsciousness”, which if present would require an assumption that the victim was extremely intoxicated and did not have capacity to consent, with the burden on the defendant to prove that she was not extremely intoxicated and did consent (917).

1.2 Application of the Law

In terms of how the law is applied, research has documented that at a variety of stages in the criminal justice system, the “credibility” of the victim is placed under scrutiny. By way of example, it has been noted in a recent report from Her Majesty’s Chief Inspector (HMCI) which reviewed the conduct of rape investigation and prosecution, that if an issue regarding the victim’s credibility, such as mental health or substance use was raised, ‘ample’ requests and checks would be made by the prosecution. There was limited indication of the same evidence gathering if similar issues regarding the perpetrator emerged (HMIC/HMPSI, 2012. This was echoed by the opinion of police officers interviewed for the report who believed that “prosecutors focused more on the reliability of the victim than on the credibility of the suspect” (ibid: 54).

This focus on the credibility of the victim at charging stage is the result of the two-stage test that the Crown Prosecution Service applies. The two stage test involves an assessment as to whether there is sufficient evidence to provide a realistic prospect of a conviction and is it is in the public interest. This test therefore requires prosecutors to second guess the assumption of jurors, who often rely on their own understandings and assumptions, which include prejudice and rape myths (Finch & Munro, 2006:318). It has been documented through mock trials that jurors come to rely on their own assumptions more heavily to make judgements when there are gaps in information.
Due to the lack of clarity within the law on “capacity”, an assessment of whether or not a survivor had the “capacity to consent” means that a survivor's behaviour may be put under scrutiny, with limited guidance as to what capacity is and at what point someone can lose capacity through intoxication. The jury, who have then been directed to answer this question through scrutiny of the survivor and their drinking or drug taking behaviour, then makes decisions about this using their existing prejudices and rape myths. If the gap in guidance on when “capacity” is lost is filled through statutory guidance however, the danger is that the prosecution is required to scrutinise any survivor’s “capacity” if they have consumed substances even when the issue of their incapacitation is not the dominant issue (Temking & Krahe, 2008: 172).

Some feminist critiques have identified that the concept of “consent” in the law as one of the reasons why rape and sexual assault cases come to rely on the scrutiny of the victim rather than the perpetrator. They have argued that the concept of consent erases the structural inequalities that define the context within which sexual intimacy and sexual relationships take place (Moore & Reynolds, 2004: 31). They have also argued that the current model of consent presents one active and one passive participant and that this model reflects a rigid definition of gender which ascribes active sexuality to men and passive sexuality to women (Malloch, 2004: 115). In this model women therefore become the ‘gatekeepers’ (Brown and Hovarth, 2009: 335) and responsible for any violation that may be inflicted upon them. In this model, if consent is passive, lack of consent can only be recognised through active physical resistance, which can be physically hampered through substances. The interference that substances can play in sexual autonomy is acknowledged through current legislation in Section 75 of the Sexual Offences Act but only in limited circumstances such as the victim being asleep or drugged; again when they have taken a passive role. What it does not recognise is the role substances can play in interfering with sexual autonomy when the victim has taken an active role in their own incapacitation.

2. Explanations of associations between rape and substance use

Cowan argues that the development of rape law has involved a:

“…recurring underlying tension as to which aspect – body or mind – should be the focal point in defining and determining the harm done through sexual assault (2007:91).

Cowan represents this “tension” in the debate on consent by noting on the one hand philosopher Heidi Hurd’s argument that “consent is an attitude, formed in the mind of the consenter” (1996:122, cited in Cowan, 2007:92) and at the other end of the spectrum, Nathan Brett’s conception of consent as a “performative action”, achieved through “speaking or doing consent” (1998:69, cited in Cowan, 2007:93). Cowan’s own argument is that rape law must move beyond “the dichotomy of mind/body”, and that “we cannot conceptualize consent without proper attention to both body and mind” (2008:903). This point is reflected in discussions in the academic literature around the role of substances, most frequently alcohol, in sexual assault. On the one hand, alcohol is conceptualised as reducing the cognitive capacity of both perpetrators and victims, while its impact on physical capacity is almost exclusively analysed in relation to victims’ intoxication.

2.1 Intoxication and cognitive (in)capacity

James Collins’ “disinhibition theory” (1982) and Claude Steele & Robert Josephs’ theory of ‘alcohol myopia’ (1990) are central to many explanations of the relationship between alcohol use and
sexual assault. Disinhibition theory suggests that alcohol has a pharmacological effect on cognition, and in particular on the areas of the brain that control inhibitions (Collins, 1982, cited in Galvani, 2004). In a similar vein, the alcohol myopia model suggests that alcohol disrupts higher order cognition which leads to a narrowing of focus, thereby reducing the drinker’s ability to access less immediate cues, leading to a ‘misinterpretation of cues’ from both parties that increases the likelihood of rape (cited in Abbey et al, 2001). In these explanations, the perpetrator is more likely to focus on his own needs and become less influenced by the possible consequences of his actions. Conversely, the victim ‘takes greater risks’ and is less likely to recognise that the perpetrator has ‘misinterpreted’ her signals of disinterest (Abbey et al, 2004:289). Survivors of DFSA interviewed by Testa and Livingston (1999) reported that they felt they missed “danger cues” that they would have noticed if they had not been intoxicated (cited in Abbey, 2004:289). This is not a theme that came out in our research, as discussed in the findings section below.

However, feminist researchers have critiqued these explanations for their potential for both victim-blaming and excusing perpetrators. Based on interviews with survivors of domestic violence whose partners had been arrested for assaulting them while intoxicated, Sarah Galvani proposes a theory of “responsible disinhibition”, noting that while most women accept the pharmacological and disinhibiting effects of alcohol, they also felt that other factors contributed and that men remained responsible for their use of violence, regardless of the effects of alcohol (2004:364). Galvani argues that the theory of responsible disinhibition:

...allows for the fact that alcohol has disinhibiting effects but argues that it is the individual’s choice how to behave under its influence; alcohol does not remove personal agency (364).

Galvani maintains that regardless of the impacts of alcohol on their cognition, perpetrators always retain the capacity to choose whether or not to use violence. However, Wallerstein highlights the potential for misinterpretation of this theory, as it was applied by Lord Judge in R v Bree, who argued that since ‘drunken intent is still intent’, ‘drunken consent is still consent’ (2009:323). Wallerstein argues that “the simple presumptive equation between intention and consent to sex is misleading,” as the law in relation to intoxicated intent applies to acts which cause harm (325).

Further, addressing evidence of victims’ reduced ability to identify and respond to “danger cues”, Jo Lovett and Miranda Horvath note that this argument should not be used to imply that if women remained sober they would avoid being raped, and that we must be clear that the responsibility for use of violence must always remain with the perpetrator (2009:128).

2.2 Intoxication and physical (in)capacity

As the critiques discussed above illustrate, judicial interpretations of the Sexual Offences Act 2003 have largely dismissed arguments that a person may become mentally incapable of giving consent (“drunken consent is still consent”), focusing instead on the point at which a person becomes physically incapable of giving consent. Similarly, many researchers have noted that intoxicated victims are less physically able to resist assault (Koss & Dinero, 1989; Testa, Livingston & Collins, 2000), and a 2007 review by Sarah Ullman notes associations found in recent research between survivors’ drinking, less resistance to assault and greater self-blame.

However, others have noted that this focus on intoxicated victims’ inability to physically resist assault does not take adequate account of bodily responses to threat that occur regardless of consumption of alcohol or other drugs. In the late 1970s, Susan Suarez and Gordon Gallup
proposed that the paralysis reported by some survivors of rape could be an example of “tonic immobility”, an adaptive response observed in animals where there is a ‘perceived incapacity to escape’ (Bados et al., 2008:517) and a need to minimise injury (Elbert and Schauer, 2010:116). Known colloquially in animals as ‘playing dead’, tonic immobility is an involuntary fear response, “characterised by freezing or immobility” (Fusé et al., 2007). A study by Arturo Bados, Lidia Toribio and Eugeni García-Grau (2008) with survivors of both sexual violence and other traumas found that over half reported significant or extreme immobility, while Tiffany Fusé and colleagues’ 2007 testing of their newly developed Tonic Immobility Scale found that tonic immobility in sexual assault survivors was comprised of two independent factors: physical immobility and fear.

As well as fear responses which may prevent women being able to physically resist an attack, Abbey and colleagues also note that regardless of substance use, sexist cultural expectations regarding women's behaviour make it difficult for women to confront men who have misperceived their behaviour, noting that many women feel “they must protect their date’s ego and let him down gently” (Abbey et al., 2004:289).

While some victims do physically resist sexual assault, many do not, and many suffer no serious physical injury (Du Mont & White, 2007). Placing undue emphasis on a woman’s decreased capacity to resist due to intoxication risks reproducing rape myths, both within the justice system and in wider society, that require “real” victims to physically resist their attacker. In rape trial simulation studies, Vanessa Munro and Liz Kelly found that jurors felt that women who were intoxicated were more likely to consent to sex, and that drunken women were responsible for giving out ‘mixed signals’ (2009:281). Munro and Kelly argue that “stereotypical constructs” of rape disadvantage victims whose cases do not match these constructs, and that responses to rape must “challenge problematic perceptions both of male sexual entitlement and of female sexual passivity” (296).

2.3 Perpetrators’ behaviour and targeting of vulnerability

Antonia Abbey and colleagues have comprehensively reviewed theoretical explanations for the relationship between alcohol use and perpetration of sexual assault elsewhere, concluding that alcohol “often acts in a synergistic manner with other variables”, such as attitudes, personality characteristics and life experiences (2004:276-7). Importantly however, they note that while attitudes (e.g. acceptance of rape myths; alcohol expectancies regarding sexuality, aggression and disinhibition) and personality characteristics (e.g. antisocial, impulsive) are associated with sexual assault perpetration, there are no attitude or personality characteristics associated with victimisation (284). While there is an association between women’s regular heavy drinking and sexual assault, Abbey and colleagues note that the direction of this relationship is not clear: perpetrators may target women who drink heavily, or survivors may use alcohol as a way to cope with symptoms of trauma (286).

In this vein, some researchers have sought to re-frame victims’ intoxication, focusing on men’s predatory behaviour in exploiting women’s vulnerability rather than victims’ reactions and behaviour; Lovett and Horvath argue for a re-focusing on “the actual agent of the assault” (Lovett & Hovarth, 2009:130). David Finkelhor proposed four preconditions for perpetration of child sexual abuse: motivation, overcoming internal inhibitors, overcoming external inhibitors and overcoming victim resistance (1984:53-68). Psychotherapist Zoe Lodrick (2010) argues that within this framework, perpetrators of sexual violence may use alcohol or drugs to overcome their own internal inhibitions, but that selecting victims on the basis of vulnerability (e.g. the victim is intoxicated) is a key factor in overcoming external inhibitions. Lovett and Horvath argue that current...
biases within the criminal justice system mean that intoxicated victims are less likely to be believed, and “provides perpetrators with relatively low-risk opportunities to assault intoxicated victims” (2009:158). Framing intoxication as a potential component of victim selection therefore has the potential to challenge victim-blaming and place scrutiny back on the perpetrator of violence and their premeditation and intent.

Finally, in his 2003 book Consent to Sexual Relations, Alan Wertheimer suggests that:

The point of respect for autonomy is to give people control over what matters to them. We cannot determine what respecting a woman’s autonomy involves until we have a better – empirically grounded – understanding of their experience with respect to intoxicated sexual relations (cited in Cowan, 2008:921).

Our research speaks to this gap in much of the literature, seeking to foreground the voices of survivors who were raped after consuming alcohol or other drugs.
Findings

One of the most striking characteristics of the group of survivors who responded to this questionnaire was the extent of re-victimisation. Rather than asking how many times they had been raped or sexually assaulted in total, we asked only for them to report how many times they had been raped or sexually assaulted after they or the perpetrator had been drinking or taking drugs. Out of 76 respondents, 43 (56.6%) had survived more than one drug-facilitated sexual assault (DFSA) and 13 (17.1%) reported surviving ten or more such assaults. For the purposes of structuring the questionnaire, we asked women to answer further questions about the sexual assault that they felt was the most serious (not what others may perceive as the most serious, but what they experienced as the most serious). However, given that the majority of respondents had experienced more than one DFSA, the requirement to focus on a single assault may have limited some respondents’ ability to communicate their views fully. Although many respondents gave very positive feedback on the questionnaire, one respondent noted of this requirement:

“This survey has asked me to choose between two rapes as to which was MORE serious. This is unacceptable… no one should be asked to rank their rapes.

Twenty-nine respondents (38.2%) chose to tell us about their experiences of an assault that occurred prior to 2003 (that is, before the Sexual Offences Act 2003). Amongst the remaining respondents, survivors most commonly chose to tell us about an assault that had happened in 2011 or 2012 (n=14, 18.4%).

1. Survivors’ views on the relationship between substance use and capacity

Of 76 respondents to the survivors questionnaire, 57 (75%) said that both they and the perpetrator had consumed substances, while seven reported that only they had consumed substances and 12 reported that only the perpetrator had consumed substances. Of those 60 respondents who provided information on the substances they’d consumed, 58 (96.7%) had consumed alcohol, with 40 having consumed it within the hour prior to being assaulted. Other substances consumed included cannabis (n=8, 13.3%), benzodiazepines (n=5, 8%) and cocaine powder (n=3, 5%). One respondent reported having taken ecstasy, one reported having taken amphetamine and one reported having used crack cocaine and heroin.

Seven survivors (11.7%) reported that they believed that they had, or may have had their drink spiked, but did not know what they’d consumed. The majority (n=47, 79.7%) of the 59 survivors who answered the question stated that they had chosen to consume alcohol or other drugs, of their own free will. However, five respondents who said they chose to consume substances also reported that they consumed substances under pressure or coercion, and four stated that as well as consuming by choice they also consumed unknowingly.

“I consumed some (wine) willingly but was pressured/coerced into having others (shots).

I was groomed from a young age to get smashed with a group of men so it was a combination of my ‘choice’ and the conditioning I’d experienced over years in an abusive relationship.

Responses from professionals broadly mirrored survivors’ experiences, with 91 (76.5%) stating that amongst their service users who had been intoxicated when sexually assaulted, the service user had ‘always’ or ‘often’ consumed substances willingly, with 15 (12.6%) reporting that they had
‘often’ consumed under pressure or coercion and six (5%) suggesting that the survivors they worked with had ‘always’ or ‘often’ consumed unknowingly (e.g. had their drink spiked).

In the survivor questionnaire, seven respondents reported that all the substances they consumed were consumed unknowingly, and six respondents reported that all the substances they consumed were consumed under pressure or coercion.

I was drinking alcohol in a bar with a group of guys, I was in control BUT suddenly was not. I believe my drink was spiked but it was never proved because the police messed up.

I started drinking and then he kept buying everyone more drinks and I felt I had to keep drinking to join in and to prove I could keep up.

One survivor who suspected having had her drink spiked suggested that her responses may also have been a result of the trauma of the assault:

I was much more intoxicated than I would normally be from what I had drunk and was also ill for 2-3 days afterwards leading me to think that my drink may have been spiked with a drug or extra alcohol, although the reaction afterwards could have been a result of trauma.

No respondents reported having been directly forced to consume substances, although a small number of professionals (n=8, 6.7%) did state that this had ‘often’ happened to survivors they worked with.

As discussed in the literature review, the law in England & Wales regarding intoxication and consent has largely been concerned with the effects of alcohol and other drugs in causing physical incapacity. With this in mind, we asked survivors to tell us how they were experiencing the impacts of substances at the time they were assaulted. As illustrated in Figure 1 below, survivors most commonly reported impacts on motor control (feeling dizzy, falling over) and that they kept falling asleep. Seven of sixty (11.7%) survivors who answered this question reported being unconscious at some point during the attack, with a further 25 (41.7%) reporting that they could not move, they kept blacking out or falling asleep, that they could not speak, or a combination of these effects. Amongst these survivors, six respondents also described having gaps in their memory, and two respondents detailed very explicitly how the rapist had targeted them:

I was passing in and out of consciousness as he raped me. I was left lying on the beach and then he came back and raped me a second time whilst I had vomit all over myself.

I fell asleep on the couch at my friend's flatmate’s [house] and did not wakeup /regain consciousness till the middle of the night when I was somehow in this man's bed and he was penetrating me. I had no memory of how I got there, let alone of giving consent.

One survivor also explained how difficult it can be to distinguish the effects of substances from her bodily responses to fear:

I felt mentally inebriated and a little bit physically unsteady. I haven’t ticked more things, because they weren't solely because of alcohol, but because of the combination of alcohol and the frightening situation I found myself in. I have therefore only ticked the things I felt before the assault began.

Of those who reported not experiencing any of these effects, one survivor reported that she was asleep, and five others reported that although they had consumed substances, they were not feeling effects that they identified as being related to their capacity. One survivor noted:
I was having a great time, laughing, joking and enjoying the effects of the drugs and drink. He took this as flirtatious and consent despite there being no physical contact prior and both of us in separate relationships and raped me.

Figure 1: Effects of substances experienced by survivors at the time they were assaulted

Survivors were fairly evenly split in their own perceptions of whether the effects of alcohol or other drugs had resulted in them being physically incapable of communicating consent to sex, with 27 (46.6%) stating that they were probably or definitely still physically capable of communicating consent (but that they did not give this consent), seven (12.1%) stating that it was possible that they were unable to communicate consent, and 24 (41.4%) stating that they were probably or definitely unable to communicate consent. Importantly, there was a clear relationship between some effects of substances and survivors’ perceptions of whether they had the ability to communicate consent. As illustrated in Figure 2, being unconscious, blacking out, having no memory of what happened, not being able to move or speak, feeling confused, vomiting and falling asleep were associated with a belief that they were probably or definitely unable to communicate consent at the time of the assault. Conversely, experiencing none of the effects listed, feeling physically sensitive to touch, feeling anxious or panicky and having no sense of time were associated with believing that they were probably or definitely able to communicate their consent at the time they were attacked. These clusters of symptoms are outlined in Table 1 below.

Figure 2: Effects of substances experienced by survivors, cross-tabulated against their beliefs about whether they were able to communicate consent
Table 1: Symptom clusters associated with survivors’ perceptions of capacity to consent

<table>
<thead>
<tr>
<th>Cluster 1: Symptoms associated with a lack of capacity to consent</th>
<th>Cluster 2: Symptoms associated with retained capacity to consent</th>
</tr>
</thead>
<tbody>
<tr>
<td>34 (57.6%) experienced one or more of these symptoms</td>
<td>31 (52.5%) experienced one or more of these symptoms</td>
</tr>
<tr>
<td>▪ I was unconscious</td>
<td>▪ Experiencing none of the effects listed</td>
</tr>
<tr>
<td>▪ I kept blacking out</td>
<td>▪ My body felt more sensitive to touch than usual</td>
</tr>
<tr>
<td>▪ I have no memory of what happened</td>
<td>▪ I felt anxious, panicky or paranoid</td>
</tr>
<tr>
<td>▪ I couldn’t move/it was really difficult to move</td>
<td>▪ I had no sense of time</td>
</tr>
<tr>
<td>▪ I couldn’t speak or had difficulty speaking</td>
<td></td>
</tr>
<tr>
<td>▪ I was confused (e.g. didn’t know where I was)</td>
<td></td>
</tr>
<tr>
<td>▪ I was physically ill (e.g. vomiting)</td>
<td></td>
</tr>
<tr>
<td>▪ I kept falling asleep/had trouble staying awake</td>
<td></td>
</tr>
</tbody>
</table>

While many survivors explained how they were physically immobilised, others also explained feeling that they lacked decision-making capacity.

*I am straight edge/T-Total, this was the first time I had consumed alcohol. I was unable to walk and he carried me to the bed and penetrated me. I was unable to communicate consent, I was unable to think straight.*

*It’s not that I couldn’t speak, I could, but I couldn’t think straight and was easily led / influenced / manipulated and therefore unable to verbally stop what was happening.*

For those survivors who were still physically capable of consenting, many explained how they had made clear their lack of consent and the perpetrator raped them anyway. Others explained how the perpetrator used physical violence or other forms of coercion to prevent them communicating, which made the effects of substances irrelevant.

*I know I definitely communicated that I did not want what was happening and I did not consent. I fought, there were bruises still a month later when I went to the police. The police gathered evidence from the restaurant bill that proved that I had drunk too much alcohol to consent. And the CPS reason for not prosecuting was that I had been drinking. I no longer have faith in any kind of justice.*

*The extreme physical violence he inflicted on me and threatened me with and sheer fear stopped me communicating a distinct no verbally. Not the drink and drugs. They usually make me more vocal.*

*...in my case, there was no question over consent. They raped me forcibly and violently and said they were going to kill me. They weren’t bothered about consent.*

*I wasn’t unconscious and i said no repeatedly but i was still assaulted.*

*I definitely didn't want to have sexual contact but was not strong enough to fight him off.*

The quote above also highlights that although this question was asking about whether survivors had capacity to consent, some survivors interpreted this as a suggestion that they could have resisted more, or differently. Indeed, throughout the questionnaire responses, many survivors were quite self-blaming and often applied prevalent rape myths to their own experience. This was perhaps most strongly expressed when survivors were asked whether they believed that they
would have still been assaulted if substances were not involved, with 30 (50.8%) stating that the assault probably or definitely would not have happened. As illustrated in Figure 3, survivors who experienced Cluster 1 symptoms were more likely to believe that their intoxication was directly linked to the attack, while those who did not experience these symptoms were more likely to say that the attack would have happened regardless of substance use.

*Figure 3: Effects of substances experienced by survivors, cross-tabulated against their beliefs about whether the assault would have happened if no substances were involved*

Survivors who felt that they would not have been assaulted if substances had not been involved in the attack provided four main explanations: i) that they would have had better judgement and not put themselves in a ‘vulnerable’ position; ii) that the intoxicated perpetrator would have had better judgement and would not have attacked them; iii) that they would have been more physically capable of resisting; or for two survivors, iv) that if they had been given the opportunity, they would have been able to consent to sex.

*I was very drunk. It impaired my judgement and I was reckless. Had I not been drunk, I wouldn't have been in a vulnerable position, and the rape would not have happened.*

*I think if he hadn't have been drinking he either wouldn't have had his inhibitions lowered so much, or wouldn't have assumed I wanted to be with him sexually, or would have paid attention to my saying no.*

*I would probably still have had sexual intercourse but it would have been my choice and I would have been an active, willing AND PROTECTED participant.*

The above respondent is highlighting that not having capacity to consent also means not being able to negotiate protected sex. This is an issue often not considered as relevant to consent but which this survivor clearly highlights as being one of the harmful elements of the assault.

Another respondent described how on two separate occasions, her incapacitation was deliberately exploited by the same perpetrator:
He had tried to coerce me many times before but I had stopped him all but one time (and that time I was ill and unable to move ...seeing a pattern here?!).

However, several survivors explicitly rejected the notion that their substance use played a role in the assault, explaining instead how the perpetrator targeted them and arguing that he would have done this regardless.

_I don't think it was my drinking that caused the rape. It was the rapist that caused the rape. And I think he would have found a way to rape me if that is what he wanted to do, regardless of the drinking. I don't think many people would think that though._ [emphasis added]

_Certain kinds of men take advantage of women when they are at their most vulnerable. I was not only under the influence of drugs, but also in bed asleep when this happened._

Professionals were much less definite about survivors in making assertions about the role of substances in sexual assault. When asked whether the assault would still have happened for survivors of DFSA they have worked with, 53 (49.1%) felt that this would ‘sometimes’ be the case, with equal numbers (n=25, 23.1%) saying that it would ‘often’ or ‘rarely’ be the case. Explanations provided by professionals included that perpetrators may target vulnerable victims, but they would assault someone anyway; that intoxicated victims are unable to defend themselves; or that the drug or alcohol dependent women they worked with were more likely to be in ‘vulnerable’ situations.

_I think that assaults are made easier for the perpetrator when alcohol/drugs are involved. But I believe that as a perpetrator they are finding ways of making the offence easier for themselves and may have committed this anyway._

_Thinking of my patients, if not addicted to drugs and or alcohol may not have been in vulnerable situations such as street sex working or in crack houses etc or with private clients._

While some survivors and professionals clearly believed substances did play a role in facilitating sexual violence, the survey demonstrated that there was not always a causal relationship between the two.

### 2. Survivors Views on the Law and Capacity to Consent

After seeking the views of survivors on their experiences of capacity and consent with regards to sexual violence and substances the survey then sought their views on the law which was explained clearly in the survey. Survivors were fairly evenly split over all possible graded responses to the question on how well they felt the law reflected their experience(s) (ranging from “does not reflect at all” to “reflects very well”), with the highest number of respondents (n=20, 28.6%) stating that it reflects their experience “somewhat well.” Comments provided on this question highlighted survivors’ own understandings of how problematic this issue can be, and the risks involved of either limiting women’s personal freedoms, or of increasing victim-blaming:

_I've had consensual drunken/stoned sex on numerous occasions and it feels infantilising to suggest any sexual activity beyond a certain but of intoxication cannot be consented to. But at the same time there are still huge problems with intoxication and sex._

_There are certain levels of intoxication where I have still felt capable of making a rational decision about sex, but I think it's really clear to see when someone is "too drunk"._
Positively it leaves it open to reflect peoples tolerance, but negatively it allows for the defence ‘I thought she was ok’, especially if the victim is unable to actually say no due to shock, trauma or the alcohol/drugs.

Some survivors also noted that the law is only one aspect of justice, and that there are other aspects of the criminal justice system that need to be addressed in relation to this issue.

I think the ‘law’ is good enough, the problem is the in the application of that law, and how rape/sexual assault victims are treated in court. It astonishes me that a defendant’s history can be kept from a jury, but a plaintiff’s entire sexual history, choice of clothing etc can be used to instil reasonable doubt.3

I think the practice and the theory do not always coincide.

As illustrated in Figure 4, when asked generally about whether someone can consent to sex while under the influence of substances rather than about their own specific experiences, most survivors (n=52, 75.4%) rejected the suggestion that it was only at the point of losing consciousness that a person loses their ability to consent to sex. As a group, there was less consensus among respondents on whether any substance use renders a person unable to consent.

Figure 4: Survivors views on intoxication and capacity to consent in general (not specific to own experience)

Perhaps unsurprisingly, Figure 5 (overleaf) highlights that survivors who were experiencing Cluster 1 symptoms (described above) when they were sexually assaulted were even more likely to somewhat or strongly disagree that a person only loses their capacity to consent when they become unconscious, to somewhat or strongly agree that a person who has been drinking cannot consent, and to somewhat or strongly agree that a person who has taken drugs cannot consent.

3 It is important to note that a ‘plaintiff’s entire sexual history’ would not be used in court, however this is the respondent’s belief which may well influence her and other victims’ decision to report to the police.
A third of survivors provided further comments in relation to their responses to these questions, with one of the central themes being that a lack of capacity to consent depends on the level of intoxication, but that this is not just about the amount consumed, but the individual themselves. In attempting to clarify the point at which someone can no longer give consent, some survivors suggested that the ability to walk and communicate were important.

*There is a line between being tipsy or drunk but knowing what is happening, and being so drunk you are passing out/ unable to understand what is happening/ unable to communicate. If a person cannot talk coherently, understand what another person is saying, or walk, I think that person cannot consent. Same with drugs.*

*When taking drugs or alcohol it is dependent on how well the person can handle substances and how much control they have over themselves at the time. If they are having trouble speaking/walking etc then I don’t consider it consent.*

*Any amount of alcohol in my system will mean I am extremely intoxicated. All I had was half a glass of wine and I couldn’t walk.*

At the same time, many respondents pointed out the importance of retaining the right to consent after using substances.

*I can still say yes or no if I’ve had some alcohol, if I’m extremely drunk I can’t consent. Otherwise I’d never be able to say yes to my partner after a glass of wine at dinner.*

While respondents made clear that substances can affect capacity to consent at particular levels of intoxication associated with certain symptoms, there was also still support for the law and its position that does not rule out the possibility of intoxicated consent.

Furthermore, in their comments, the respondents highlighted their ‘lived experience’ of the ‘Zinberg Triangle’ (Zinberg, 1986), a key tool in understanding how and why the same substances impact on people differently, but also impact differently on the same person in different circumstances. The Zinberg Triangle takes into consideration the drug, the set (person or mindset of the person taking the drug), and the setting (the environment in which the person is taking the drug). This suggests that, to a certain extent, each case must be assessed individually to establish levels of intoxication and capacity to consent.
3. Impact of substance use on survivors’ ‘telling’ about being sexually assaulted

Unlike most other violent crimes, victims of sexual violence will be unwilling to disclose their experiences to others because of the likelihood of not being believed, being blamed for the assault or because of greater levels of guilt, fear and shame. We therefore felt it important to ask survey respondents about whom they disclosed to and to assess what factors relating to the assault might affect their disclosure patterns.

The majority of survivors who answered the question about who they spoke to about the assault had disclosed to friends or family (n=39, 57%). However in this survey, 22 out of the 69 respondents (31.9%) reported that they did not tell anyone at all. A significant proportion of this group (n=10 out of 22) were referring to an assault that occurred before 2003. In fact for respondents who were assaulted before 2003, 40% told no one at all. If the assault was during or after 2003, however, 27% told no one at all.

One respondent described that whilst she did not tell anyone about the assault that took place over 25 years ago, she still believes that she needs support for what happened:

_The whole school thought it was sex. No one knows it was attempted rape. I'm building up to telling my husband and possibly accessing some professional support_

For others, even though they did eventually tell someone, it took a considerable amount of time:

_Not at the time but over ten years later i did talk to my counsellor and my partner_

_not then but have now some 28 years later_

For one respondent, even though others witnessed the attack, she still answered that she had been unable to disclose to others:

_My 'friends' saw him rape me and found it funny..._
The survey also asked whether the survivor had told ‘a worker at a Sexual Assault Referral Centre (SARC) or Rape Crisis Centre’, ‘a doctor’, ‘the police’ or ‘a worker at another service’. The professional most likely to be told (or also told) about the assault was a worker at a SARC or Rape Crisis Centre (n=15, 22%), following this it was a doctor (n=14, 20%), the police (n=13, 19%) and then a worker at another service (n=7, 10%). SARC and Rape Crisis Centres were the most likely service to act as the single point of disclosure, i.e. the survivor reported only to them (n=4). All of those that only reported to a SARC or Rape Crisis Centre, when asked why they did not report to the police selected the answer "I felt that reporting would put me at risk of further violence from the perpetrator or from someone else". All of those who reported to the police also told someone else.

Figure 7. Disclosure types by number of disclosure

Who survivors disclose to

When separated into cluster one and cluster two symptoms (see figure 8), those with cluster one symptoms were far more likely to report four or more times, and were also more likely to report to the police and to a doctor. They were also less likely to only disclose to a family or friend. All respondents who only disclosed to a Rape Crisis Centre or a SARC were also in the cluster one category. Victims with cluster two symptoms appear much more likely to tell only one person, and most often this was a family or friend.

Figure 8. Disclosures broken down by cluster one symptoms (left) and cluster two symptoms (right)
Respondents therefore displayed resistance to speaking with services about the assault and many to disclosing to any one at all about the violence they had experienced.

4. Experience of the Criminal Justice System

4.1 Reporting to the Police

As this research was designed to consider the law and its effectiveness, the survey asked respondents specifically about experiences of reporting to the police or reasons for not reporting to the police. Overall, of survivors who responded to the question about reporting, 19% (n=13) had reported to the police although when limited to those who reported during or after 2003, 25% (n=11) had reported the incident to the police.

Among those who did report to the police, 54% (n=7) had a negative or very negative experience, 23% said their experience was neutral (n=3), and 8% (n=1) had a very positive experience. When asked how drugs or alcohol consumption impacted on the police treatment of them, 47% (n=6) said that they believed it had impacted negatively or very negatively.

We received some further comments from those who had reported to the police. All of these however were in relation to their general experience with the police rather than specifically in relation to drugs or alcohol. Negative experiences included:

- They didn't care that I had taken drugs, but overall the experience was negative because I delayed in reporting due to fear.
- They left me in a room on my own for 5 hours before someone saw me. Eventually they took me home, kicking in my door to get me in. Operation Sapphire then didn't contact me for another 7 hours, by which time I had decided against pursuing a conviction due to mental/physical trauma
- The police were terrible throughout the whole ordeal and I can completely understand why women do not report rapes after experiencing this. At first, the first police officer I had dealings with was ok, but after that it was downhill all the way.

Positive experiences were also discussed:

- I was a police officer (as was the perpetrator) at the time of the assault. It was extremely difficult for me to make the decision to report the incident, but when I did, the male officer (not a specialist) who I initially reported it to and the female officer (specialist) who took a second statement were fantastic

Participants who describe their experience as neutral did not leave any comments, however there were two comments from our interviewees that indicated they had seen positive change or had had positive experiences:

- Yeah but nowadays it seems to be a lot better.
- ...they appeared to believe me and be non-judgemental. I think that if I hadn't had the Sapphire Liaison officer I wouldn't be sitting here talking to you now.

Generally however, those who participated in the research believed that the police had been or would be unsympathetic. One interviewee noted:
It’s hard because, like, I know a lot of Met Police Officers and there’s a real police mentality and it’s quite masculine and I think that alone puts you off, the attitudes in the police, and I don’t know how you change that without changing society in general.

Other survey respondents explained how they had come to have a perception of the police as likely to be unsupportive and blaming and therefore chose not to report:

I had reported a sexual assault previously to the police and they blamed me for that, I didn’t feel up to being blamed again.

The hospital had no sympathy and blamed me so I was sure the police would do the same.

In addition to concerns about a lack of support, respondents provided a variety of reasons for not reporting the assault to the police. The reasons respondents did not report to the police were varied. Of the 64 people who did not contact the police, the most frequently selected reasons from a list of multiple-choice answers were:

- “I did not believe I would access justice” (44%, n=28)
- “I did not feel I would be believed” (42%, n=27)
- “I did not want others to find out” (38%, n=24)
- “I did not wish to confront the perpetrator” (36%, n=23)
- “I believed it was my fault” (34%, n=22)
- “I knew the perpetrator” (33%, n=21)
- “I felt that reporting would put me at risk of further violence from the perpetrator or from someone else” (22%, n=14).

When these responses were split into cluster one and cluster two symptoms, those with cluster one symptoms were slightly more likely to state “I believed it was my fault” (n=15 in comparison to n=9 in cluster two symptoms) and that “I did not want to confront the perpetrator” (n=13 compared with n=10).

In order to ascertain how important a factor the use of substances was in participants’ decision not to report, we asked those who did not report if they would have been more likely to have done so if drugs and/or alcohol were not involved in some way. Of the 28 respondents with cluster one symptoms who did not report, 18 (64%) said that they would have been more likely or much more likely to report had drugs or alcohol not been involved. Only six (21.4%) of those with cluster one symptoms who did not report said that the likelihood of them reporting would have remained the same, had alcohol or drugs not been involved. Of the 35 survivors with cluster two symptoms who did not report, only eight (22.8%) said that they would be more likely to report had drink or drugs not been involved. Those with cluster two symptoms who did not report most commonly said that the chance of them reporting had drink or drugs not been involved would be about the same (n=11, 31.4%).

Furthermore, of those survivors who believed that the incident would probably or definitely not have happened had drugs and/or alcohol not been involved only three reported to the police and 19 (59%) said that they would have been more likely to report to the police had drugs and/or alcohol not been involved. One interviewee described her initial response:
Very initially I refused to believe it had happened and then when people were saying ‘do you want to report?’ I was like ‘no, they’re not going to believe me, I was drinking’

A survey respondent noted that the response of others to high profile cases where the victim had consumed substances also put her off from reporting:

I am afraid of the perpetrator’s reaction and of having to face him again. Also, the recent media around the Ched Evans case has frightened me enormously

This data paints a brutally bleak picture. Survivors of sexual violence are generally reluctant to report to the police primarily because of a fear of not being believed or being able to access justice; moreover, those survivors who were the most intoxicated at the time are caught in a trap – the substances which facilitate the assault also constitute a barrier to reporting to the police.

4.2 Experiences of the criminal justice system beyond reporting

Overall, this research found that both survivors and professionals share caution with regard to the treatment that survivors may face from the police and within the larger criminal justice system. When professionals were asked “how seriously do you think police take cases of sexual assault where the survivor was intentionally intoxicated, in comparison to other assault cases”, 37% (n=39) said that it would be taken much less seriously and 33% (n=35) said slightly less seriously. When asked if conviction would be as likely when the survivor had been intentionally intoxicated 44% (n=47) believed a conviction would be much less likely, while 26% (n=28) stated that conviction would be slightly less likely.

Of the survivor survey respondents who reported to the police (n=13), only two of the perpetrators were charged. One interviewee described the problems she encountered at charging stage because of the fact that she had been intoxicated at the time of the attack:

part of the reason why the CPS didn’t prosecute was because I’d been drinking, which has always confused me because the police did actually have evidence...I think they said 8 times over the drink-drive limit with the amount I was supposed to have consumed that night. So I don’t quite understand how the lawyers can say that you can’t consent when you’ve been drinking and yet the CPS say that because I’d been drinking that’s the reason they couldn’t prosecute […] the drinking was part of the reason why I delayed going but it was also partly the delaying that was one of the other reasons why the CPS didn’t prosecute.

Of those two respondents whose cases were being taken forward by the Crown Prosecution Service, one respondent felt she was unable to go to court and the other was awaiting trial. The survey was therefore unable to assess the impact of substance use on a survivor’s experience at court or on criminal justice outcomes.

5. Attitudes of others towards drug facilitated sexual assault

As discussed in the literature review, attitudes towards sexual violence are considered to be one of the main barriers to reporting sexual violence or to obtaining a successful criminal justice outcome. The attitudes of others can also impact considerably on a victim/survivor’s wellbeing and recovery from their trauma. For this reason we asked respondents to explain their beliefs about how others would perceive drug-facilitated sexual assault.
Overwhelmingly, survivor survey respondents felt that, if the victim or survivor of an assault had drunk alcohol or taken drugs prior to an assault they would be less likely to be believed or supported by others (see figure 5): 98% (n=63) of respondents said that people were less likely or much less likely to believe in the survivors story, 95% (n=61) thought people were less likely or much less likely to be supportive of the survivor, and 84% said that people were more likely or much more likely to be critical of the survivor’s actions. The majority of respondents (78%, n=50) also felt that if a victim had consumed drugs or alcohol this would make others less critical of the actions of the perpetrator.

Figure 9. Attitudes of others if survivor has consumed drugs or alcohol prior to assault

Two of our interviews identified how they had initially internalised the blaming attitude of others:

...that’s why I was interested in the Ched Evans case, because I feel like that’s exactly what happened to me, the same situation. And people are making judgements on this girl because she was on drugs or alcohol...and that reflects my own experience as to what people were saying to me as well, and I kind of believed it a little bit.

...for a long time I thought it was my fault because I’d been drinking. I don’t believe that any more but for a long time, 2 or 3 years, I thought it was my fault or partly my fault and that I’d put myself at risk and therefore had brought it on myself somehow.

In contrast to the above, when the survivors survey asked about how others were likely to perceive an assault if a perpetrator had consumed drugs or alcohol before attacking someone, the majority of respondents said that it would make no difference to attitudes towards the survivor (see figure 6). 49% (n=32) of respondents said that it would make no difference as to whether or not others would believe in the survivors story, 52% (n=33) of respondents said it would make no difference as to how supportive they were of the survivor, and 58% of respondents said that it would make no difference as to how critical they were of the survivor. When asked how critical other people would be of the perpetrator when they had consumed alcohol, 34% of respondents said that it would make no difference as to how critical they would be of the perpetrator’s actions but 32% said that it would make others less critical of the perpetrators actions.
Respondents further commented that while the drug or alcohol consumption of victims is likely to increase the probability that they will be blamed for an assault, if a perpetrator uses drugs or alcohol prior to committing the offence it can actually lead others to excuse or downplay their responsibility:

Makes no difference because most men and women too will claim 'poor man' he was so drunk the woman initiated sexual contact and now she is claiming he raped her.' Males often consume a little alcohol in order to justify [sic] their right to sexually attack women. Alcohol doesn't cause men to commit sexual violence against women rather men make choice to subject women to sexual violence.

I think often having consumed alcohol is seen as a defence for perpetrators, like they weren't in control of themselves and they should be given support to deal with their drug problems or anger issues. It means that they don't have to take responsibility because society supports this.

Although I think most people would believe the survivor's story, it would probably "help" the perpetrator's case to be able to hide behind drink or drugs. "If he wasn't on drugs, that wouldn't have happened." "You do have to remember though, he was drunk - he wouldn't normally do something like that."

I think sometimes people can be more supportive of the perpetrator; they have the attitude that as he was drunk, he may not have realised that he was raping someone and it was all just a drunken accident; on the other hand, sometimes they are more supportive of the survivor, because they accept that a man under the influence of alcohol may have behaved in a way they assume is out of character and made a dreadful "mistake"

Our interview participants also articulated that drugs and alcohol can be a means to excuse the actions of perpetrators:

...alcohol gives them a good way of blaming her you know in the same way that clothes do...so they find all these ways of blaming women and alcohol is merely one of those ways, one other way to blame the victim and not the perpetrator I think
...drugs and alcohol use are being used as a very easy way of letting men off the hook for rape. That’s basically what it is and if it was something else we’d find something else but things go in fashions

Survivors were very clear therefore that they believed that drug and/or alcohol consumption negatively impacted on the support and belief of others towards the victim but that it could positively impact on their attitude towards the perpetrator.

6. Impact of assault on future substance use

The survey asked survivors whether their use of substances had changed since they had experienced the assault. Out of 64 responses to this question 25% (n=15) reported that their substance use had increased, 32.8% (n=21) that it had stayed the same and 43.8% (n=28) said that it had decreased. Those with cluster one symptoms were twice as likely to say that their substance use had greatly increased (cluster one n=5 in comparison to cluster two n=3) or slightly increased (cluster one n=5 in comparison to cluster two n=2).

Numerous survivors described how the assault had made them more wary or cautious of using substances:

For a number of years afterwards I was afraid of being drunk. I think it took around 20 years for me to realise why.

First I drank shit loads. Now, I don’t drink or do drugs ever. I’m never losing control again

I now only drink in situations where I feel safe - so very rarely - as he was supposed to be a friend I could trust.

Don’t drink alcohol in a public setting any more because I’m always wary of men watching me and seeing how much I have consumed. I know male perpetrators are cunning and they target women who have drunk alcohol no matter how small the amount.

I haven’t been out drinking in a pub since, I have never been back to that pub (which is a gay pub) so my options for socialising are greatly reduced.

I am scared of being in a similar situation so I drink much less (it was unusual for me to drink that much though).

Too scared to drink amongst people who are not my friends

I stopped smoking cannabis as it made me paranoid whenever I tried it again after this assault had occurred.

I did not have an alcohol problem then, I was drinking socially with my then partner. I now find it difficult to drink and enjoy myself.

I have been the victim of sexual abuse since I was a little girl, over the years various different people have assaulted me with alcohol/drugs not always playing a part. For my own peace of mind I don’t get drunk because through the help of a rape crisis centre I feel more able to halt a future attack. I know from experience that if somebody wants to attack you they will whether you are drunk or not, I personally prefer to have clarity of mind just in case.

However, some survivors did report using substances as a way to cope with their experiences of sexual violence:
I never used to take drugs but now I do on a monthly basis. Usually class A. It helps me forget about things.

I drank more to try and avoid the emotional pain I was feeling.

Initially, I found that I turned to alcohol and cannabis to cope with the assault. By the time I was 19, I was, whenever I was drinking, binge drinking. Even though I'd repressed the memories, I think my subconscious was still telling me that something was up. I still find myself turning to alcohol on occasions where I find myself triggered.

On the whole it has decreased, but I have suffer from rape-related PTSD and do have episodes of drug/alcohol binges that exceed any drug/alcohol use I had previously.

I've used more drugs and alcohol almost as a control/coping mechanism - to prove that it doesn't happen every time.

Greatly increased after the attack, and over time now deal with the pain more healthily

Amongst this survey sample, therefore, it was most likely that substance use had decreased since the attack due to survivors feeling less comfortable when out of control or being in situations where they may experience a similar attack. Experiences of sexual violence that involve substance use can, however, also increase victims’ use of substances to cope with the trauma of the assault.

Interestingly, the professionals survey indicated that practitioners think survivors who used substances before the assault were more likely than other survivors to start or increase substance use after the assault: 36% (n=37) said that survivors who had used before the assault were much more likely to begin or increase use afterwards, and 21% (n=22) stated it was slightly more likely. This is in considerable contrast to survivors’ own perception of how their substance use changed subsequent to the assault. In answer to the survey question to that effect, 64 respondents stated their use had:

- greatly increased (13%, n=8) or slightly increased (11%, n=7)
- stayed the same (33%, n=21)
- greatly decreased (36%, n=23) or slightly decreased (9%, n=5)

The discrepancy between survivors' and professionals' perception of survivors’ substance use before and after then assault may partially be explained by the fact the professionals are more likely to be in touch with survivors who have substance use problems.

Overall professionals were broadly in agreement that DFSA is associated with an increased rate of common emotional responses to trauma, including displaying post-traumatic stress disorder (n=42, 42%), anger (n=53, 52%), anxiety (n=58, 56%) and depression (n=56, 54%). The greatest differences, however, were in relation to shame and guilt. 61% (n=63) and 70% (n=71) of professionals stated that survivors who use substances prior to an assault were slightly or much more likely to feel shame and guilt, respectively, than survivors who had not.
It is also worth noting that in each case, between 17 and 45 professionals (17%-44%) were not sure if survivors of DFSA were more or less likely to experience these difficulties following an assault. Overall, this points to a need for increased awareness among professionals about the associations between DFSA and common responses to trauma.

7. Support for victims and survivors

We asked interviewees about what kind of support services victims and survivors of sexual violence might need in general and specifically when they had consumed drugs or alcohol prior to the attack.

Despite the many ways in which being assaulted and/or raped may have affected the physical health and psychological wellbeing of the many survivors who responded to the survey, relatively few accessed support to meet their health needs. Fourteen respondents talked to a doctor about the assault, and fifteen respondents also sought support from a Sexual Assault Referral Centre (SARC) or Rape Crisis Centre. Considering their respective remits, it is logical to assume that medical professionals, such as a GP, and specialist sexual violence services would offer support for both physical and psychological difficulties following an assault.

Reflecting existing research on health responses to mental ill-health (for example, Holly and Scalabrino, 2012), this research highlighted a common criticism of mainstream health support services – the lack of time and willingness to engage with the problem and not the symptoms of their trauma:

_The doctor’s just want to put you on drugs. Doctors they just give you anti-depressants and you’re out in five minutes, they don’t want to talk about anything, they don’t want to talk about_

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4 It is worth noting that the survey was distributed partially by SARC and Rape Crisis workers which may contribute to the high number of respondents who have used either service.
the cause, they don’t really deal with referring you somewhere, you have to get all of that help yourself.

Conversely, almost of our interviewees – even those who had not used the services – identified the importance of specialist support for survivors of sexual violence:

*I was quite fortunate to have a crisis centre in my area, but I know they’re not everywhere, so I think there should be a rule about how far you can live from one. That should be a priority for a government.*

*Well I just think that they just need more of it. It’s incredibly difficult to get through to the helplines isn’t it?*

*I think survivors of sexual assault need a lot more support than they have. I think I’ve been extremely lucky*

*I’ve heard about rape crisis centres and things (I haven’t actually been to one of them), but I guess that would be quite useful for a lot of people who have encountered sexual assault as well.*

Sexual Assault Referral Centres (SARCs) can also be a vital place to receive initial medical attention and signposting. However, there are variations depending on area in terms accessibility and provision, particularly for those who want to self-refer and do not want initial police involvement but would to have forensic evidence taken at the earliest possible stage and improve their options later on. Regardless of whether or not a survivor reports to the police a SARC is also a useful place to signpost to sexual health services and Rape Crisis services such as Independent Sexual Violence Advisors (ISVAs) and counselling.

If victims or survivors do want to report, support in the criminal justice system is crucial. For those survivors who had taken substances prior to the assault, this may be a means to receive critical validation and belief in their experiences. One interviewee described what would have helped her most through the criminal justice process:

*...one of the things that I think is really missing from the system, is there needs to be some kind of legal representation for the victim to help guide you. So I never knew, I never had the chance to talk to the CPS, I never knew that I was allowed to talk to the CPS, who it was I could talk to in the CPS about their decision and I think there needs to be some kind of, you know, somebody who is on your side because the Sapphire Liaison Officer isn’t on your side they’re still the police trying to be impartial and ‘innocent until proven guilty’.*

When asked what victims and survivors who had taken substances prior to assault require most in terms of support, another interviewee noted that:

*I don’t think that one category needs special treatment I think what they all need is understanding and no judgement and compassion and a way to access services which will help them to deal with what happened and to re-build their life.*

In this view, therefore, survivors who have consumed substances before being attacked are not a particular group that require particular services but rather support can be sufficiently encompassed within existing specialist sexual violence agencies. That said, however, experiencing sexual violence when intoxicated can which increase the likelihood of memory loss, guilt, fear and shame
meaning that ‘the role of believing survivors of DFSA and validating their experience is critical’ (Gauntlett-Gilbert, Keegan & Petrak, 2004:220). It also means that they are less able to come forward and seek support. Public awareness campaigns and education on the support available therefore needs to be centred on sharing belief in and validation of a survivors experience and reassurance that a victim is never to blame. Our interviewees gave examples of the sorts of messages that these might include:

*It doesn’t matter if he drugged me because he shouldn’t have raped me anyway and it doesn’t matter if he was high because he shouldn’t have raped me anyway*

*it’s not your fault that he chose you because, you know because he chose you because he was a rapist, not because you were drunk because there were other sober men there or there were other men who might have been drunk as well who weren’t rapists and they didn’t rape you, it was the rapist who chose to rape you*

*1 in 6, 1 in 4, 1 in 8 it depends what survey you read but whatever, if it was even 1 in 20 that’s lots of us and if we just raised our voices and said this has happened and it shouldn't have done then maybe people would see that it’s not just one or two boozed up girls one night it’s happening to everybody from all walks of life all the time, so I think...something has to change…*
Conclusion

The findings of this research demonstrate that the concept of “capacity to consent” is relevant and important to some survivors who were intoxicated at the time of assault and that a symptoms-based approach could be a useful means to assess “capacity” within the criminal justice system. The concept is not relevant for all survivors however, particularly for those who had consumed substances prior to being assaulted but for whom intoxication was not the primary means through which the attack was facilitated. What was most strongly communicated through this research, however, is that whether the concept of “capacity to consent” is relevant or not, victims and survivors who consumed substances before the assault frequently face even greater barriers to achieving justice than survivors who had not been drinking or taken drugs. They also experience additional stigma and disbelief about the harm they have experienced if substances were consumed prior to them being sexually assaulted or raped.

Some of the findings of this report are in line with other research in this area. In most incidents, for example, survivors and perpetrators had both voluntarily consumed alcohol alongside or as opposed to other substances (EMCDDA, 2008:6; Papadodima et al, 2007; Lovett and Hovarth, 2009) and that the most common relationships between the victim and perpetrator was as an acquaintance or stranger (Stanko & Williams, 2009). This, it is suggested by some researchers, is because substances can better enable an assault and also prevent the disclosure of assault when there is no prior relationship between the victim and the perpetrator (Harrington, Cleveland et al, 1999: 52; Abbey, 2011: 486; Kelly, et al, 2005: 81). Also in correspondence with recent research, the majority of survivors who answered the question about who they spoke to about the assault had disclosed to friends or family (Ministry of Justice, Home Office and the Office for National Statistics, 2013).

As is common with other research in this area, the majority of the assaults discussed by survey respondents had not been reported to the police (Ministry of Justice, Home Office and the Office for National Statistics, 2013). In the main, respondents didn’t report because of a perception that they would not have been able to access justice, wouldn’t be believed or would be blamed for their assault. Survivors and professionals both held a clear perception that cases were taken less seriously in the criminal justice system when alcohol or drugs had been involved and for many survivors their substance consumption actually created a barrier to them reporting in the first place. For those who did report to the police, most described their experience as a negative one and believed that their consumption of substances had negatively impacted on the police’s response to them. Our research was unable to comment on how the consumption of drugs prior to assault can impact on criminal justice outcomes or experiences beyond reporting, because at the time of completing the survey, only two of the respondents’ cases had reached charging stage and no case had yet reached the court arena.

What was particularly unique to this research was that respondents were offered the opportunity to define whether or not they believed they had had the “capacity to consent” when they were assaulted. They were also able to provide their opinion about how drugs and alcohol were connected to the assault and to comment on the current position that the law takes on “capacity to consent”. What the research found is that respondents were divided about whether or not they were able to communicate consent and whether the assault would still have happened had substances not been consumed. Indeed, many respondents believed that it was important to be able to retain the right to consent when using drugs and alcohol even though capacity could be lost through intoxication. The current overall position of the law that a person can be too incapacitated
to consent before becoming unconscious but that intoxication does not result in immediate incapacity, is therefore appropriately in line with the overall response from our survey respondents. This is because it provides the necessary flexibility to protect personal freedoms while also enabling the possibility of prosecuting when consent is disabled.

What is still not clear in the law however, is how the loss of capacity through intoxication can be assessed within a criminal justice framework and just how the prosecution could potentially prove that someone was too incapacitated to consent. In her suggestions for amendments to the Sexual Offences Act, Sharon Cowan (2008) proposed using a cluster of symptoms, which if present, would require an assumption of extreme intoxication and therefore a lack of capacity to consent. Cowan proposed symptoms such as “vomiting, inability to speak or move, memory loss, or periods of unconsciousness” (917), and these symptoms were clearly associated, in our research, with survivors’ own belief that they were incapable of communicating their consent because of intoxication and that therefore substances were a key means through which the assault was facilitated. Sharon Cowan’s symptom-based approach in ascertaining capacity to consent, therefore, very much correlates with the victim experiences voiced in our survey.

These findings indicate that further research should be pursued to explore how this approach could be usefully used in investigating, prosecuting and legislating against sexually violent crime. Indeed, crown prosecutors may already use this approach in certain cases and therefore research that reviews recent prosecutions of drug-facilitated sexual assault could be usefully undertaken to explore whether or not using a symptoms-based approach in collecting evidence and in presenting a case to a jury, supports a successful outcome at court. If this is proved to be the case, then it could prompt a productive discussion about how this approach could be applied throughout the criminal justice system.

One of the benefits of using a symptoms-based approach is that it is not dependent on a specified measure of substance use to indicate incapacity. This would correlate with the survey respondents’ views that there was not a universal measure of substance use that could always correctly diagnose incapacity to consent. Instead, many respondents felt that substances affect people according to their own tolerance and circumstances. Using a symptom-based approach would provide this flexibility.

For victims and survivors who did not experience extreme motor-control related symptoms they mostly believed that they would have been able to communicate consent at the time of assault but that this was not given or obtained. For these victims, if a symptom-based approach to capacity was somehow better incorporated into criminal justice proceedings, it may enable police to see that the focus in questioning and throughout the investigation should not be in relation to what substances have been consumed but instead look at what evidence there is to indicate that consent was not present, for example evidence of violence, threats or coercion. If found, the prosecutor can then build a narrative that focuses on how these tactics were used by a perpetrator rather than engaging with the myths and stereotypes that surround substance use and sexual violence. Again, further research on how a symptoms-based approach relates to the circumstances of an attack (e.g. the level of threat, violence or coercion involved) would provide clearer guidance in this area.

Whatever the symptoms of intoxication and whether or not the victim or survivor had capacity to consent at the time, what the findings of this survey demonstrate is that there are very negative societal attitudes attributed to victims and survivors who have been drinking or taking other
substances prior to being sexual attacked. Perhaps as a result of this negative social attitude, a considerable number of respondents told us that, at the time, they believed the attack was somehow their fault and that this is why they didn’t report to the police. This was particularly the case for those with symptoms of impeded motor-control. It is therefore important that professionals working in this area understand that there may be additional needs in recovering from the trauma of the assault when drugs or alcohol have been involved and that these victims may be more likely to have amnesia and fragmented memories and increased feelings of guilt and self-blame as a result of the physiological effects of substances consumed at the time (Gauntlett-Gilbert, Keegan & Petrak, 2004). There is also evidence to suggest that the physiological effects of drugs can make enduring PTSD more likely (ibid: 220). If this is appropriately considered, efforts to support victims and survivors can be appropriately targeted. It may also prevent victim-blaming and potentially re-traumatising messages around responsibility that are often seen in prevention campaigns issued by the police and other statutory agencies.

While the survey did not ask respondents for their opinion as to why these negative attitudes exist, some interviewees raised concerns about the current model of ‘consent’ in a way that could be considered to offer a partial explanation for these attitudes:

*I think consent is such a weird concept anyway. Yeah, it doesn’t seem good enough. I can’t say why, really, it just seems to have such an odd sounding meaning. It sort of like you permit someone to do stuff and that’s weird…passive rather than aggressive, with kind of male/female stuff.*

*consent is such a nebulous concept anyway isn’t it…I don’t know about you but I’ve never consented to sex in my life, I have participated actively in sex, that’s what normal people do when they have sex, they participate actively, they don’t consent to having something done to their bodies…*

If, as these interviewees suggest, society views consent as passive, the physical sexual act is not sufficient to ascertain the “reasonable belief” of the perpetrator in law because consensual sex is always assumed to contain one passive participant. The active actions of the victim before the incident (e.g. drinking, online dating, friendliness) are therefore scrutinised to ascertain whether or not it was reasonable for the perpetrator to believe that they consented. Consequentially, these actions then become a means to blame the victim for the incident. With a more balanced understanding of consent, evidence of a person’s extreme intoxication (e.g. struggling to walk, stand or talk) would actually be an indication that they were or were becoming incapacitated and would therefore no longer be able to actively participate. Scrutiny may then be turned on the behaviour of the perpetrator as to how they then behaved towards this incapacitated person. For incidents where perpetrators used substances to incapacitate victims and for incidents where drugs and/or alcohol were consumed but were not essential to enable the attack, active and positive participation on the part of the victim is not present or possible. Nevertheless, the victim-blaming myths attributed to sexual violence and substance use presently overshadow both of these forms of assault.

Whatever the reason behind them, it is important that agents of the criminal justice system counteract victim-blaming myths through their own attitude and approach to enable better outcomes in sexual offences cases. Nina Burrowes suggests that if prosecutors use a narrative which “focuses on the defendant’s motives and behaviours and counteracts any narratives that use common rape myths to hold the complainant responsible” (Burrowes, 2013; p24) then juries will be better equipped to issue guilty verdicts. Burrowes suggests one way of doing this is to show the
jury the way in which sex offenders use incapacitation as a tactic to assault and avoid being caught, moving the scrutiny of behaviour away from the victim and onto the perpetrator. Providing evidence of symptoms of the victim’s intoxication could potentially support this approach by offering a more structured model for prosecutors and police in assessing “capacity” in cases of drug-facilitated sexual assault.

This alternative narrative in presenting drug-facilitated sexual assault cases at court must also be accompanied by prosecutors adopting a ‘merit-based’ approach for sexual offence cases which ‘proceed on the basis of a notional jury which is wholly unaffected by any myths or stereotypes’ (Saunders, 2012). Assessment of cases using this approach means that the negative social attitudes potentially held by the jury are not used against the victim or survivor at charging stage and even before this through the attitude or decision making of the police. In conjunction with non-victim blaming attitudes and narratives being adopted by agents of the criminal justice system and a clearer means of assessing capacity, this could, in the long-term, provide a possible means of improving conviction rates in rape and sexual assault cases where substances have been consumed. It is only through pursuing these sorts of possibilities, informed by survivors’ own views, that the ‘justice gap’ (Munro & Kelly, 2009) that currently exists in relation to drug-facilitated rape and sexual assault, can ever even begin to be rightfully addressed.
Recommendations

- Further consultation should be conducted with survivors and professionals on a symptom-based approach to ascertaining capacity to consent in relation to intoxication to inform a structured model and clear guidance for professionals throughout the criminal justice system.

- Further research to explore the extent to which the symptoms-based approach is already being used and could be further utilised in investigating, prosecuting and legislating against violent crime is required. This should include a review of recent prosecutions of drug-facilitated sexual assault to explore whether or not using a symptoms-based approach in collecting evidence and in presenting a case to a jury, supports a successful outcome at court. If this is proved to be the case, then it could prompt a productive discussion about how this approach could be applied throughout the criminal justice system.

- Training for police officers on investigating reports of drug-facilitated sexual assault. Adopting a symptoms-based approach, in questioning and throughout the investigation, police would focus on what evidence is available to indicate that consent was not present, rather than focus on what substances had been consumed.

- Nina Burrowes' guidance on how incapacitation is used as part of perpetrator tactics in sexual offending should be disseminated to prosecutors and to specially trained officers.

- Continued and improved implementation of a merits-based approach to prosecution of sexual offences including checks and reviews.

- The Crown Prosecution Service Guidelines on Prosecuting Child Sexual Abuse cases (2013) state that if “the victim has been, or is, abusing drink or drugs” or their account they give in “inconsistent”, this should be understood as a possible indicator that abuse has taken place rather than undermining the victim’s credibility. This approach should be adopted by the CPS and the police also in relation to adults.

- Review judicial directives given to juries on rape and sexual assault cases should include a direction which relates to rape myths connected to substance use.

- Increased and easier access to specialist sexual violence services, Sexual Assault Referral Centres (SARCs), Independent Sexual Violence Advisors (ISVA’s) and sexual violence counselling services. Self-referrals to SARCs are particularly important to enable evidence, including toxicological evidence of substances, to be gathered in a timely fashion and in a way in which survivors can chose whether or not to report to the police.

- Training for other relevant practitioners, including GPs, nurse, mental health professionals, drug and alcohol workers, who may have contact with survivors of drug-facilitated sexual assault to counter common rape myths and promote engagement with specialist support services such as SARCs and ISVAs.

- Research to collate survivor views on ‘consent’ with an aim to provide effective educational resources and public awareness campaigns.

- Police prevention campaigns relating to sexual offences and alcohol to focus messages on perpetrator behaviour rather than on victim responsibility. This may require that a single national police prevention campaign be designed and implemented in consultation with the voluntary sector in order to prevent the continued use of victim-blaming campaigns continuing to be launched by police authorities throughout the country.
References


R v. Bree [2007] EWCA 256


Appendix 1: Rapid Evidence Assessment Protocol

The overarching REA question is:
1. How is the use of alcohol or other drugs understood to impact on “capacity to consent” to sexual activity?

Within this, the specific questions are:
1. In relation to intoxication, how is “capacity to consent” to sexual activity defined in UK law?
2. What is the medical understanding of the incapacitating effects of alcohol and other drugs on the body?
3. What do sexual violence professionals believe about intoxication and “capacity to consent”?
4. Is there any existing literature which considers survivors definitions of “capacity to consent” in relation to intoxication? If so, what are the conclusions?

Inclusion and exclusion criteria
- Include academic and grey literature
- Time: Last 15 years only (1997 – 2012)
- Language: English language only
- Population: Medical, legal and sexual violence professionals; survivors.

Sources to be searched:
- CSA Illumina (http://www.csa.com/csaillumina/login.php)
- Department of Health Publications (http://www.dh.gov.uk/health/category/publications/)
- Drug & Alcohol Findings (http://findings.org.uk/)
- DrugData (http://drugdata.drugscope.org.uk/)
- EBSCO Discovery Service (http://www.ebscohost.com/discovery/eds-content)
- ESRC Research Catalogue (http://www.esrc.ac.uk/impacts-and-findings/research-catalogue/)
- Google; GoogleScholar (first 50 hits only) (http://scholar.google.co.uk)
- Home Office Research & Statistics (http://homeoffice.gov.uk/science-research/research-statistics/)
- Ingenta Connect (http://www.ingentaconnect.com/)
- J-Stor (http://www.jstor.org/)
- Westlaw UK and World (http://www.westlaw.co.uk/)
- National Institute for Health & Clinical Excellence (http://guidance.nice.org.uk)
- OpenGrey (http://www.opengrey.eu/)
- Policy Hub (http://www.nationalschool.gov.uk/policyhub/)
- SafetyLit (http://www.safetylit.org)
- ScienceDirect (http://www.sciencedirect.com/)
- The existing AVA library.

Search terms:
- [rape OR “sexual violence”] AND [drug OR alcohol OR substance]
Appendix 2: Survivors questionnaire

Survey participation

a) Do you consent to having your answers to this survey analysed for a report, to be published by AVA, on the definition of "capacity to consent" to sexual activity under English law? All of your answers will be anonymised but they may be quoted in the report.

Yes
No

Eligibility

b) Are you aged 16 or older?

Yes
No

c) Have you been sexually assaulted since you turned 16 years old?

By "sexually assaulted" we mean anyone touching you in a way that you felt was sexual, when you didn't want them to. For this survey, we are including rape and assault by penetration within the term "sexual assault".

Yes
No

d) In any incidents of sexual assault which have occurred since you were 16 years old had either you OR the perpetrator drunk alcohol or taken drugs before the assault took place?

This may have been alcohol or drugs you had chosen to take, or alcohol or drugs you had unknowingly taken or taken against your will.

Yes
No

e) Did your experience of sexual assault OR the criminal justice process occur in England and/or Wales?

Yes
No

Drugs and alcohol use

f) How many times have you been sexually assaulted after you OR the perpetrator had been drinking and/or taken drugs?

When did the most serious assault of this type occur?
By 'most serious', we mean the assault that YOU consider to be the most serious, not what you think the law or anyone else might consider to be the most serious.

Before 2003
2004
2005
2006
2007
2008
2009
2010
2011
2012

We would now like you ask you about the MOST SERIOUS sexual assault you have experienced, where you or the perpetrator had been drinking and/or taking drugs before the assault occurred. Again, by 'most serious' we mean the assault that YOU consider to be the most serious.

g) Was it you or the perpetrator who had drunk alcohol or taken drugs before the most serious assault took place? This may have been alcohol or drugs you had chosen to take, or alcohol or drugs you had unknowingly taken or taken against against your will.

Myself
Perpetrator
Me and the perpetrator

h) Before the most serious assault where you had been drinking and/or taking drugs, what substances had you consumed?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Up to 1hr before the assault</th>
<th>1-2hrs before the assault</th>
<th>2-3hrs before the assault</th>
<th>3-4hrs before the assault</th>
<th>4-5hrs before the assault</th>
<th>5-6hrs before the assault</th>
<th>Over 6hrs before the assault</th>
<th>Not consumed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<td>Amphetamines (speed, phet, whizz, base, dexies)</td>
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<td>Benzodiazepines (tranquillisers, downers e.g. diazepam, Rohypnol)</td>
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<td>Cannabis (marijuana, weed, pot, resin, skunk, dope, grass)</td>
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<td>Cocaine power</td>
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</table>
Up to 1hr before the assault | 1-2hrs before the assault | 2-3hrs before the assault | 3-4hrs before the assault | 4-5hrs before the assault | 5-6hrs before the assault | Over 6hrs before the assault | Not consumed
---|---|---|---|---|---|---|---
Ecstasy (pills, MDMA) | | | | | | | |
Gamma-hydroxybutyrate (GHB, GBL) | | | | | | | |
Heroin/opiates (brown, gear, smack, morphine) | | | | | | | |
Ketamine (green, K, special K, super K, vitamin K) | | | | | | | |
Mephedrone (meph, miaow, meow meow) | | | | | | | |
Unknown white powder | | | | | | | |
Other (specify below) | | | | | | | |

i) How were the drugs or alcohol consumed? (please tick all that apply)

- [ ] I chose to consume them intentionally (of my own free will e.g. to feel less stressed, have fun etc)
- [ ] I consumed them unknowingly (e.g., I had my drink spiked)
- [ ] I was pressured or coerced into consuming them (e.g., I felt like I had to take drugs or alcohol even though no one forced me to directly)
- [ ] I was forced to consume them (e.g., I was physically restrained and made to take drugs or alcohol or threats were made against me or someone I knew if I didn't take drugs or alcohol)

j) At the time of the most serious assault, which of the following effects do you believe the alcohol and/or drugs that you had consumed were having on you? (Please tick all that apply)

Please note that we are asking this question rather than asking you how much you consumed, because we know that different people experience the effects of alcohol and other drugs differently, regardless of whether they've consumed similar amounts. We also know that even if you had consumed something, you may not have felt any effects and this information is important too.

- [ ] I was unconscious
- [ ] I couldn't move/it was really difficult to move
- [ ] I kept blacking out
- [ ] I kept falling asleep/had trouble staying awake
- [ ] I was physically ill (e.g. vomiting)
- [ ] I was dizzy/falling over/bumping into things
I was hallucinating
I was confused (e.g. didn't know where I was)
I couldn't speak or had difficulty speaking (e.g. others couldn't understand what I was saying)
I felt anxious, panicky or paranoid
My body felt more sensitive to touch than usual
My vision was distorted (e.g. seeing double)
I had feelings of being separated from my body
I had no sense of time (e.g. time going fast, time going slow, speeding up or slowing down)
I felt very emotionally sensitive
I have no memory of what happened
None of the above

Please tell us about any other effects the alcohol/drugs were having on you at the time of the assault, or expand on the answers you've given above.

We know that there are many different ways that perpetrators use their power to sexually assault someone, including physical violence, coercion and threats, regardless of whether alcohol or drugs are involved. However, to help us critique the law in its current form, we want to ask you two questions about what impact YOU believe alcohol or drugs had on your physical and mental capacity at the time you were assaulted.

Whilst we are asking you these questions in line with current laws, we want you to know that WE believe that whether you were physically or mentally capable of communicating or not is not important: the perpetrator is always 100% responsible for his choice to be sexually violent.

k) At the time of the most serious assault, to what extent do you believe that drugs and/or alcohol were affecting your physical ability to communicate that you didn't want sexual contact with this person?

- I believe I was definitely unable to communicate because of drugs and/or alcohol
- I believe I was probably unable to communicate because of drugs and/or alcohol
- It's possible that I was unable to communicate because of drugs and/or alcohol
- I believe I was probably still able to communicate despite the drugs and/or alcohol
- I believe I was definitely still able to communicate despite the drugs and/or alcohol
- Don't know

l) At the time of the assault, to what extent do you believe alcohol or other drugs were affecting your ability to decide whether or not you wanted to have sexual contact with someone?

- I believe I was definitely unable to make this decision because of drugs and/or alcohol
- I believe I was probably unable to make this decision because of drugs and/or alcohol
It's possible that I was unable to make this decision because of drugs and/or alcohol

I believe I was probably still able to make this decision despite the drugs and/or alcohol

I believe I was definitely still able to make this decision despite the drugs and/or alcohol

Don't know

### Drugs and Alcohol Use: Perpetrator

**m) Before the same most serious assault, had the perpetrator consumed drugs or alcohol?**

- Yes
- No
- Don't know

**n) Before the most serious assault where drugs and alcohol had been consumed, what substances had the perpetrator consumed?**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Up to 1hr before the assault</th>
<th>1-2hrs before the assault</th>
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<th>4-5hrs before the assault</th>
<th>5-6hrs before the assault</th>
<th>Over 6hrs before the assault</th>
<th>Consumed but don't know when taken</th>
<th>Don't know consumed/Don't know when taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>C</td>
<td>C</td>
<td>C</td>
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<td>Ecstasy (pills, MDMA)</td>
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<td>Gamma-hydroxybutyrate (GHB, GBL)</td>
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<td>Heroin/opiates (brown, gear, smack, morphine)</td>
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<td>Ketamine (green, K, special K, super K, vitamin K)</td>
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<td>Mephedrone (meph, mephedrone)</td>
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4-5hrs before the assault
5-6hrs before the assault
Over 6hrs before the assault
Consumed but don’t know when taken
Consumed but don’t know when taken

miaow, meow meow)
Unknown white powder
Unknown - they were intoxicated but I don’t know the substance
Other (specify below)

Perpetrator information

o) In the same, most serious assault what was your relationship with the perpetrator?

□ Partner/ex-partner
□ Parent/step-parent
□ Other relative
□ Friend
□ Acquaintance
□ Stranger

p) What was the gender of the perpetrator of this most serious attack?

Male
Female
Non-binary
Prefer not to say

q) If you knew the perpetrator, do any of the following statements describe their behaviour before the assault? (please tick all that apply)

□ This person was stalking or harassing me
□ This person had sexually assaulted me previously
□ This person had threatened to sexually assault me previously
□ This person had been physically violent towards me
□ This person had threatened physical violence towards me
□ This person had been physically violent to other people or animals
□ This person had threatened physical violence towards other people or animals
□ This person had tried to control my behaviour
□ I felt frightened of this person
This person had belittled me or made me feel worthless
I had previously called the police in relation to this person's behaviour towards me or others
This person had NOT been violent, threatening or controlling in any way

r) How far do you agree with the following statements?

Please note that here, by 'sex' we mean any sexual activity.

| Strongly |
|----------|----------|----------|----------|----------|
| agree    | agree    | disagree | disagree | disagree |

Someone always has the right to choose whether or not to have sex

If someone is in a sexual relationship they can choose whether or not to have sex at any given time

If someone has been kissing or touching someone else they can still choose whether or not to have sex

If someone has taken drugs or alcohol it is only when they become unconscious that they lose the ability to freely decide whether to agree to sex

If someone has been drinking they are NOT able to freely choose whether to agree to sex

If someone has taken drugs they are NOT able to freely choose whether to agree to sex

s) Do you believe that this most serious assault would still have happened had drugs and/or alcohol not been used?

Check one:

- Definitely yes
- Probably yes
- Maybe
- Probably not
- Definitely not
- Don't know

According to the law in England and Wales, having drunk alcohol or taken other drugs does not necessarily mean that you will be unable to agree freely to sexual activity. The law does say that it's impossible to agree to sexual activity if you're unconscious, but it also says that if you've drunk alcohol or taken other drugs, you may become physically incapable of agreeing to sexual activity without actually being unconscious.

1) Thinking about your own experience, do you think that the law reflects the reality of what it's like to be affected by alcohol or other drugs and being sexually assaulted or raped?
v) Did you tell anyone about the most serious sexual assault before which you or the perpetrator had consumed drugs and/or alcohol? (please tick all that apply)

☐ Yes, to the police
☐ Yes, to a doctor
☐ Yes, to a worker at a rape crisis centre or sexual assault referral centre
☐ Yes, to a worker at another service
☐ Yes, to a friend/family member
☐ Yes, to a partner
☐ No

w) If you reported the most serious assault before which you or the perpetrator had consumed alcohol and/or drugs to the police, was your experience with them

☐ Very positive
☐ Positive
☐ Neutral
☐ Negative
☐ Very negative

x) Do you believe that the drugs or alcohol you had consumed influenced the police's treatment of you?

☐ Impacted very positively
☐ Impacted positively
☐ Had no impact
☐ Impacted negatively
☐ Impacted very negatively
☐ Don't know
☐ Not applicable

y) For this most serious assault which you reported was your case taken by the Crown Prosecution Service?
z) Did the perpetrator claim that they believed that you consented in this case?

☐ Yes
☐ No
☐ Don’t know

aa) Was the perpetrator cross-examined on their intoxication during this case?

☐ Yes
☐ No
☐ Don’t know

bb) What was the result of this court case?

☐ Don’t know
☐ The perpetrator was convicted of rape/sexual assault
☐ The perpetrator was convicted of another offence
☐ The perpetrator was not convicted

cc) If you did not report the most serious assault before which you and/or the perpetrator had used drugs and/or alcohol to the police, why not? (please tick all that apply)

☐ I did not want others to find out
☐ I did not feel I would be believed
☐ I did not want to confront the perpetrator
☐ I did not believe I would access justice
☐ I believed it was my fault
☐ I knew the perpetrator
☐ I felt that reporting would put me at risk of further violence from the perpetrator or from someone else
☐ Don’t know
☐ Not applicable

dd) Would you have been more likely to report if you or the perpetrator had not consumed drugs and/or alcohol?

☐ Much more likely
ee) If a survivor of sexual violence has taken drugs or alcohol prior to the assault, do you think it will change how others perceive the assault?

- More likely
- About the same
- Less likely
- Much less likely
- Don't know
- Not applicable

ff) How do you think the reactions of others to a sexual assault changes when the survivor has consumed alcohol and/or drugs?

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<tr>
<th></th>
<th>Much more</th>
<th>More</th>
<th>No difference</th>
<th>Less</th>
<th>Much less</th>
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</thead>
<tbody>
<tr>
<td>They will believe in the survivor's story</td>
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<td>They will be supportive of the survivor</td>
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<tr>
<td>They will be critical of the actions of the survivor</td>
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<tr>
<td>They will be critical of the actions of the perpetrator</td>
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</table>

gg) How do you think the reactions of others to a sexual assault changes when the perpetrator has consumed alcohol and/or drugs?

<table>
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<tr>
<th></th>
<th>Much more</th>
<th>More</th>
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</table>

hh) How has your use of drugs and/or alcohol changed since the first time you were sexually assaulted?
Greatly increased
Slightly increased
Stayed the same
Slightly decreased
Greatly decreased
Appendix 3: Professionals questionnaire

Survey participation

1. Do you consent to having your answers analysed by AVA for the purposes of producing a report which reviews the definition of "capacity to consent" to sexual activity under English and Welsh law? All of your answers will be anonymised but may be used in the publication of a report.

☐ Yes
☐ No

2. Do you work with clients who are 18 years of age or over?

☐ Yes
☐ No

3. Have any of your clients in the past 18 months been survivors of sexual violence?

☐ Yes
☐ No
☐ Don’t know

Your occupation

4. Which sector do you work in?

☐ Voluntary sector
☐ Statutory sector
☐ Private sector
☐ Social enterprise

5. In what area of support does your organisation primarily provide services? (tick all that apply)

☐ Criminal justice system
☐ Domestic violence
☐ Family support
☐ Health/medical
☐ Housing/homelessness
☐ Involvement in prostitution
Legal advice/representation
Mental health
Police
Research organisation/academic
Sexual health
Sexual violence
Substance misuse
Youth work

6. What is your primary role?

7. Which area do you work in?

East Midlands
East of England
Greater London
North West England
Scotland
South West England
Yorkshire & Humber
North East England
Northern Ireland
South East England
West Midlands
Wales
Guernsey
Isle of Man
Jersey
None of the above

8. Which local authority/ies do you provide services in (in your own role, not your organisation as a whole)?

Drugs used in DFSA

9. Of the clients you have worked with in the past 12 months:
a) Approximately how many were survivors of sexual assault?
b) Approximately how many had used alcohol and/or drugs prior to the assault?

10. In your work with survivors of sexual violence who have consumed alcohol and/or drugs prior to the assault, how often have they:

<table>
<thead>
<tr>
<th>Consumed substances intentionally (i.e. of their own free choice)</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
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<table>
<thead>
<tr>
<th>Consumed substances unknowingly (e.g. had their drink spiked)</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
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<table>
<thead>
<tr>
<th>Been pressured or coerced into consuming them</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
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<table>
<thead>
<tr>
<th>Been forced to consume them</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
### 11. For those survivors who had consumed substances prior to the assault, who was the perpetrator?

<table>
<thead>
<tr>
<th>Category</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male partner/ex-partner</td>
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<tr>
<td>Female partner/ex-partner</td>
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<tr>
<td>Father/step-father</td>
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<tr>
<td>Mother/step-mother</td>
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<tr>
<td>Other male relative</td>
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<tr>
<td>Other female relative</td>
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<tr>
<td>Male friend/acquaintance</td>
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<tr>
<td>Female friend/acquaintance</td>
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<tr>
<td>Male stranger</td>
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<tr>
<td>Female stranger</td>
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</tbody>
</table>

### 12. Amongst survivors who you have worked with who had consumed substances intentionally, what substance/s had they taken prior to the assault?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Amphetamine</td>
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<tr>
<td>Benzodiazepines (tranquillisers e.g. diazepam)</td>
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<td></td>
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<tr>
<td>Rohypnol</td>
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<tr>
<td>Cannabis</td>
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<tr>
<td>Cocaine power</td>
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<tr>
<td>Crack cocaine</td>
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<tr>
<td>Ecstasy</td>
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<tr>
<td>Gamma-hydroxybutyrate (GHB)</td>
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<tr>
<td>Heroin/opiates</td>
<td></td>
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<tr>
<td>Ketamine (special K, super K, vitamin K)</td>
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<tr>
<td>Mephedrone (meph, meow meow, m-cat)</td>
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<td></td>
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<tr>
<td>Unknown white powders</td>
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<tr>
<td>Other (specify below)</td>
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</tbody>
</table>
13. Amongst survivors who you have worked with who had UNKNOWINGLY consumed substances, what substance/s had they been given prior to the assault?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Amphetamine</td>
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<tr>
<td>Benzodiazepines (tranquillisers e.g. diazepam)</td>
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<tr>
<td>Rohypnol</td>
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<td>Cannabis</td>
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<tr>
<td>Cocaine power</td>
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<td>Crack cocaine</td>
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<tr>
<td>Ecstasy</td>
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<tr>
<td>Heroin/opiates</td>
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<tr>
<td>Ketamine (special K, super K, vitamin K)</td>
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<tr>
<td>Mephedrone (meph, meow meow, m-cat)</td>
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<td></td>
</tr>
<tr>
<td>Unknown white powders</td>
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<tr>
<td>Other (specify below)</td>
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</tbody>
</table>

14. Amongst survivors who you have worked with who had been PRESSURED/COERCED/FORCED to consume substances, what substance/s had they taken prior to the assault?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Amphetamine</td>
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<tr>
<td>Benzodiazepines (tranquillisers e.g. diazepam)</td>
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<td></td>
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<tr>
<td>Cannabis</td>
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<tr>
<td>Cocaine power</td>
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<tr>
<td>Crack cocaine</td>
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<tr>
<td>Ecstasy</td>
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<tr>
<td>Gamma-hydroxybutyrate (GHB)</td>
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<tr>
<td>Heroin/opiates</td>
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<tr>
<td>Ketamine</td>
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</tbody>
</table>
Capacity to consent

15. Do you believe that alcohol impairs a person’s capacity to consent to sexual activity?

☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Don’t know

16. Do you believe that drugs (other than alcohol) impair a person’s capacity to consent to sexual activity?

☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Don’t know

17. Thinking about the incidents of drug or alcohol facilitated sexual assault that you have worked with, do you believe that the assault would have taken place if drugs and alcohol had not been involved, all else being the same?

☐ Always
☐ Often
☐ Sometimes
☐ Rarely
☐ Never
☐ Don’t know
### Needs of Drug-Facilitated Sexual Assault survivors

18. In comparison to other survivors, how often do survivors who have used substances prior to the assault experience the following responses:

<table>
<thead>
<tr>
<th></th>
<th>Much more often</th>
<th>Slightly more often</th>
<th>About the same</th>
<th>Slightly less often</th>
<th>Much less often</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agoraphobia</td>
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<tr>
<td>Anger</td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Eating problems/disorders</td>
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<tr>
<td>Guilt</td>
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<tr>
<td>Memory loss of the event</td>
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<tr>
<td>Not recognising the encounter as assault</td>
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<tr>
<td>Physical injury</td>
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<tr>
<td>Post Traumatic Stress Disorder (diagnosed)</td>
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</tr>
<tr>
<td>Post Traumatic Stress Disorder (undiagnosed, displays symptoms)</td>
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<tr>
<td>Pregnancy</td>
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<tr>
<td>Self-harming behaviours</td>
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<tr>
<td>Shame</td>
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<tr>
<td>STIs</td>
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<tr>
<td>Substance use beginning or increasing</td>
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<tr>
<td>Suicide</td>
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</tbody>
</table>

19. If a survivor of sexual violence consumed alcohol and/or drugs prior to the assault, do you think they will be more or less likely than other survivors to:

<table>
<thead>
<tr>
<th></th>
<th>Much more likely</th>
<th>Slightly more likely</th>
<th>About the same</th>
<th>Slightly less likely</th>
<th>Much less likely</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disclose the incident to a friend</td>
<td></td>
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<tr>
<td>Disclose the incident to a family member</td>
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<tr>
<td>Disclose the incident to a professional</td>
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<tr>
<td>Report the incident to the police</td>
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<tr>
<td>Give evidence in court against the perpetrator</td>
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</tbody>
</table>
20. In your experience, how does the MEANS through which the survivor consumed substances impact on the likelihood that they will report the incident to the police, when compared with other survivors?

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Much more likely to report</th>
<th>Slightly more likely to report</th>
<th>About the same</th>
<th>Slightly less likely to report</th>
<th>Much less likely to report</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>In cases where the survivor INTENTIONALLY consumed substances</td>
<td></td>
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<tr>
<td>In cases where the survivor UNKNOWINGLY consumed substances</td>
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</tr>
<tr>
<td>In cases where the survivor was PRESSURED/COERCED into consuming substances</td>
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</tr>
<tr>
<td>In cases where the survivor was FORCED to consume substances</td>
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</tbody>
</table>

21. In your experience, how seriously do you think the police take cases of sexual assault where the complainant has used drugs or alcohol, in comparison with other sexual assault cases?

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Much more seriously</th>
<th>Slightly more seriously</th>
<th>About the same</th>
<th>Slightly less seriously</th>
<th>Much less seriously</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>In cases where the survivor INTENTIONALLY consumed substances</td>
<td></td>
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</tr>
<tr>
<td>In cases where the survivor UNKNOWINGLY consumed substances</td>
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</tr>
<tr>
<td>In cases where the survivor was PRESSURED/COERCED into consuming substances</td>
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<tr>
<td>In cases where the survivor was FORCED to consume substances</td>
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</tbody>
</table>

22. In your experience of cases of sexual assault, does the use of drugs and/or alcohol by the complainant make a conviction for rape or sexual assault:

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Much more likely</th>
<th>Slightly more likely</th>
<th>About the same</th>
<th>Slightly less likely</th>
<th>Much less likely</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>In cases where the survivor INTENTIONALLY consumed substances</td>
<td></td>
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<tr>
<td>In cases where the survivor UNKNOWINGLY consumed substances</td>
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</tbody>
</table>
23. In comparison to other survivors, do you think that the experience of the criminal justice system for survivors who have consumed drugs and/or alcohol prior to the assault is:

- Much better
- Slightly better
- About the same
- Slightly worse
- Much worse
- Don't know

24. Under the Sexual Offences Act 2003, being drunk or otherwise intoxicated does not automatically remove a person’s capacity to consent to sexual activity. However, the law recognises that someone may become so intoxicated as to lose the physical capacity to give consent before the point at which they lose consciousness.

In your experience, do the current provisions in the law sufficiently reflect the experiences of victims who are intoxicated at the time of the offence?

- Always
- Often
- Sometimes
- Rarely
- Never
- Don't know

25. If you were able to make any changes to the law relating to rape and consent, what would these be?

26. Thinking about survivors of drug-facilitated sexual assault who you have worked with, have toxicological investigations of the survivor’s drug/alcohol level been taken?

- Always
- Often
27. In your experience, how long after the rape or sexual assault do survivors wait to have their toxicology sample taken?

<table>
<thead>
<tr>
<th></th>
<th>Within 1hr</th>
<th>Within 2hrs</th>
<th>Within 3hrs</th>
<th>Within 4hrs</th>
<th>Within 6hrs</th>
<th>Within 8hrs</th>
<th>Within 12hrs</th>
<th>Within 24hrs</th>
<th>Within 48hrs</th>
<th>Within 72hrs</th>
<th>Over 3 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quickest timeframe you can recall</td>
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<tr>
<td>On average</td>
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<tr>
<td>Longest timeframe you can recall</td>
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</tbody>
</table>

28. How frequently are delays in toxicology samples being taken due to the following:

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Often</th>
<th>Sometimes</th>
<th>Rarely</th>
<th>Never</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors don't present to the police or Sexual Assault Referral Centre (SARC) immediately</td>
<td></td>
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<tr>
<td>Survivors are not given the option of having a toxicology sample taken</td>
<td></td>
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<tr>
<td>The police don't take a toxicology sample promptly after the survivor presents to them</td>
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</tr>
<tr>
<td>The SARC doesn't take a toxicology sample promptly after the survivor presents to them</td>
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<td>Survivors are still too intoxicated to consent to a toxicology sample being taken</td>
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<td>Survivors are unwilling to consent to a toxicology sample being taken</td>
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<td>Other (please specify below)</td>
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29. In your experience how frequently are survivors' toxicology results used in court?

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<th>Always</th>
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30. In your experience, how are the survivors’ toxicology results used in court?

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<th></th>
<th>Always</th>
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<td>By the prosecution to argue that the survivor didn't have the capacity to consent</td>
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<td>By the defence to argue that the survivor's testimony is unreliable</td>
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Appendix 4: Semi-structured interview guide

NOTE FOR PERSON CONDUCTING THE INTERVIEW: If a woman becomes distressed you should immediately ask her if she would like to stop the recording and take a break. She should then be offered the opportunity to have a discussion in private if there is more than one interviewer in the room. If it is clear that she would like further support then she can be signposted to relevant services and the interviewer should follow up with the participant a day or two after the interview has taken place.

- Thank you for completing our survey and thank you for agreeing to come and be interviewed today; we really appreciate you taking the time to take part in this research.
- We want to hear your views and ideas about the impact of drugs and alcohol on incidents of sexual assault and in particular how they may affect how people who survived sexual assault are treated by others and supported through the legal system.
- Your anonymous views will form part of a report that will provide guidance on how services and organisations, such as rape crisis centres and the police, can better support people who have been affected by drugs or alcohol at the time of a sexual assault.
- Mention by ‘sexual assault’ we mean any touching that a person didn’t want and we include rape and assault by penetration within our definition of ‘sexual assault’, which is the term we will be using throughout the interview.
- We want to know if the law in England and Wales on intoxication and sexual assault is working effectively.
- It is totally up to you as to how much you wish to share about your personal experiences and we will not require you to answer questions about these.
- We acknowledge that the topics which we are covering can be difficult and upsetting. You are in no way obliged to answer any of the questions and are free to stop the interview at any time. If you start to experience anxiety, distress or relive traumatic experiences in anyway please indicate that you would like to take a break. You can also stop and ask us questions at any time we are also available if you wish to talk privately with any of us during or after the session has ended.

The first thing I’m going to talk you through is the information sheet and consent form I’ve just given you (participants will have been sent the information sheet which includes informing them that we will be audio recording in advance of the group. Stella Project Coordinator to go through with each participant and make sure they understand and consent). Do you have any questions you’d like to ask before we start? You’ll notice from the form that we’re going to be recording the discussion today so it’s important that you agree to take part and be recorded. The first thing I’m going to ask you is to provide a fake name for the recording and then we’ll go on to the first questions. We’ll aim to do the interview within a half-hour. If it goes beyond that I’ll just check whether you’re ok to continue after 30 minutes.

Take questions then collect in signed consent forms.
I’m going to start the recorder now. (Start recorder)

Using a fake name, to make sure no-one can identify you, can you please introduce yourself for the purpose of the recording.

What we’re going to talk about today are some of the connections between drugs, alcohol and sexual assault. We want to find out about how you believe drugs and alcohol could impact on an experience of sexual assault. We also want to hear how you think being affected by drugs and/or alcohol at the time of an assault might impact on a person’s experiences of getting the help and support they need to recover and get justice. There are no right or wrong answers or comments. If you have any views that you do not feel able to share then you can talk to us or contact us after the interview.

1) How did you come across the survey? How did you find completing it?
Follow up questions/prompts
○ Thank you for filling it out
Did any questions stand out for you?

2) In the survey we asked a collection of questions around how and when people are freely able to choose to engage in sexual activity and particularly in relation to drugs and alcohol. In your answers you mentioned...... Would you like to tell me more about that?

○ Can any of the effects of drugs/alcohol mean that someone is no longer able to agree to sex or sexual activity?
○ Does being intoxicated mean that someone is automatically less able to fully agree to sex or sexual activity?
○ What signs or behaviours might indicate that someone is too intoxicated to consent?
○ Given the range of situations and factors that can limit a person’s ability to consent (such as age and ability and relationship with perp), how important do you think intoxication is?

3) In our recent online survey of people who had survived sexual assault when they or the perpetrator had been affected by drugs or alcohol, the majority of respondents said that they would have been more likely to report had drugs and/or alcohol not been involved. You said you...... What is it about the use of drugs and/or alcohol by the victim that you think makes many people less likely to report to the police and try and get the perpetrator convicted for their crime?

**Follow up questions/prompts**

○ In responses to our survey we found that people who had unknowingly consumed drugs or alcohol (eg drink spiking) were more likely to report to the police than those who had consumed drugs or alcohol intentionally. Do you have any ideas about why this might be the case?
○ One of the three main reasons given by people who completed the survey to explain why they did not report was that they ‘did not believe they would access justice’ – do you think accessing justice is more difficult for people who have consumed drugs/alcohol prior to being assaulted? If so, how/why?
○ Is there anything that the police or the legal system could do to change this reluctance?

4) In our recent online survey, participants said that if someone had consumed drugs or alcohol before being assaulted then the people around them would be more critical of their actions and less likely to believe and support them. Why do you think this is the case?

**Follow up questions/prompts**

○ Do you have any ideas about how this could be changed?
○ Survey participants also said that people would be less critical of the perpetrator’s actions if they had taken drugs or alcohol. Why do you think this is the case?

5) Because they are less likely to be believed and supported do you think this means that people who have consumed drugs and/or alcohol prior to the assault need greater support from services?

**Follow up questions/prompts**

○ What additional support might they need?
○ Who do you think would be best placed to provide it? (examples might include women’s support services, youth centres, sexual health, the police).
○ Do you believe that there is enough support available for survivors of sexual assault generally?

6) Are there any comments that you would like to make or add on any of the topics we’ve discussed today or on the issue of sexual violence, drugs and alcohol?

That’s the end of today’s interview. As mentioned in the information sheet, we’ll be putting your anonymous views into a report, together with the findings of our online surveys. The Stella Project is going to use this to critically review the law in England and Wales relating to these issues and to produce guidance for services that support people who have experienced sexual assault.

Thank you very much for taking the time to be here today, we hope that the report will collect and showcase the views of people who have direct experience of these issues and challenge existing myths and
stereotypes. We will call you in a couple of days to see if you have any further questions about what we’ve discussed. If you would like to contact us yourself and ask us any further questions you have a letter in your pack with our contact details on and information about other places that provide support.