

A Problem of Attrition: The Impact of a Complainant's Mental Health on the Investigation and Prosecution of a Rape Allegation

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ABSTRACT

This thesis addresses the relevance and impact of a complainant's mental health on the investigation and prosecution of a rape allegation. There is evidence to suggest that an allegation made by a complainant with a mental health condition is more likely to drop out of the criminal justice process than one without a mental health condition.¹ In light of this occurrence, the thesis considers the extent to which there is a connection between the presence of a mental health issue and the likelihood of the allegation being withdrawn – a decision which is made by either by the police, the Crown Prosecution Service or the complainant herself – or discontinued. The thesis examines the relevance and impact of a mental health condition as it arises in key investigative and prosecutorial stages: the initial reporting of the allegation, the complainant's interview with the police, the process of pre-trial disclosure and the deployment of material relating to the complainant's mental health at trial. It considers how mental health can influence the assessment of the complainant's credibility, the quality of the account of the offence, and ability to participate in the judicial process. The thesis finds that mental health is influential in its connection to the attrition of rape cases, with potential ramifications for the complainant, the allegation, and attrition both within and across the key procedural stages. Ultimately, the influence of mental health on the case is cumulative.

¹ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

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ABBREVIATIONS

ABE	Achieving Best Evidence Interview
ACPO	Association Chief of Police Officers
AG	Guidelines Attorney General's Guidelines on Disclosure
CPS	Crown Prosecution Service
CRIS	Crime Reporting Information System
DSM-V	Diagnostic and Statistical Manual of Mental Disorders
ECHR	European Convention on Human Rights
FME	Forensic Medical Examiner
HMCPSI	Her Majesty's Crown Prosecution Service Inspectorate
HMIC	Her Majesty's Inspectorate of Constabulary
HO CR	Home Office Counting Rules
ICD-10	International Classification of Diseases
ISVA	Independent Sexual Advisors
Mental Health APP	Mental Health Authorised Professional Practice
NPCC	National Police Chiefs' Council
OCD	Obsessive Compulsive Disorder
PTPH	Plea and Trial Preparation Hearing

PTSD	Post-Traumatic Stress Disorder
SARC	Sexual Assault Referral Centre
SMI	Severe Mental Illness
SOA 2003	Sexual Offences Act 2003
SOIT Officer	Officer Sexual Offences Investigative Techniques
VAWG	Violence against Women and Girls
YJCEA 1999	Youth Justice and Criminal Evidence Act 1999

CHAPTER 1: Introduction

Outline of research

This thesis is concerned with the relevance and impact that a complainant's mental health has on the investigation and prosecution of a rape allegation. It will examine the correlation between the presence of a mental health issue and the likelihood of attrition, that is to say, the prospect of a case failing to progress to trial and attain a conviction.² Attrition is a pressing issue, making this research an important contribution to sexual offences reform.

This thesis addresses the relevance and impact of a complainant's mental health on the investigation and prosecution of a rape allegation. Research indicates that persons with mental health issues are at an increased risk of victimisation. Furthermore, there is an increased risk of being the victim of a rape if you are a woman and you have a mental health issue. There is evidence to suggest that an allegation that concerns a complainant with a mental health condition is more likely to drop out of the criminal justice process than one without a mental health condition.³ In light of these occurrences, the thesis considers the extent to which there is a connection between the presence of a mental health issue and the likelihood of the allegation/case being discontinued; a decision, which is made by either by the police, the CPS or the complainant herself.

² Essentially, 'attrition is the process by which rape cases fall out of the criminal justice system'. J Brown and M Horvath, *Rape: Challenging Contemporary Thinking* (Routledge 2009) 8.

³ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

Certain factors affect rape complainant credibility and are therefore influential of juror acceptance of the complainant's account of events at trial.⁴ They include, but are not limited to, delayed reporting of the allegation, having made a previous complaint of a sexual nature, having a previous sexual relationship with the accused and having consumed alcohol at the time of the offence.⁵ These factors affect the chances of securing a conviction. There is evidence to suggest that an allegation that concerns a complainant with a mental health condition is more likely to drop out of the criminal justice process than one without a mental health condition.⁶ This thesis examines specific procedural stages and decisions in the life of such cases. It considers decisions regarding progression or discontinuance that are made at a particular procedural point and how such decisions are connected with, and may be influenced by, issues of mental health in complainants.

The framework of the criminal justice process, i.e. the account of events, scrutinises the evidential credibility of both the complainant and the complaint. This thesis therefore refers to the accuracy, coherence and completeness of the complainant's account in discussions of evidential quality. The evidential quality – and therefore the perceived strength of the case – can be affected where mental health is an issue, and it is suggested that an evidentially weaker case is less likely to progress.

The key procedural points in the investigation and prosecution of a rape complaint examined here include: the initial reporting of the rape to the police, the complainant's interview with police (the Achieving Best Evidence Interview), the

⁴ L Ellison and V Munro, 'Of 'normal sex' and 'real rape': Exploring the use of socio-legal scripts in (mock) jury deliberation' (2009) 18 *Social Legal Studies* 291, J Temkin and B Krahé, *Sexual Assault and the Justice Gap: A Question of Attitude* (OUP 2008).

⁵ J Temkin, 'And always keep a hold of nurse, for fear of finding something worse': challenging rape myths in the courtroom' (2010) 13 *New Crim L Rev* 710.

⁶ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

process of pre-trial disclosure and the use of counselling records or therapy notes as part of cross-examination of the complainant at trial. These procedural stages each serve different functions and have different objectives and are therefore the subject of separate chapters placed in context within the overall thesis.

Thesis framework and methodology

I have adopted a chronological structure that mirrors the different steps of the criminal justice process, from reporting, to investigation prosecution and, finally, the trial itself, any of which might be affected by a complainant's mental health issues. This enables the reader to follow the different procedure steps of the criminal justice system in a natural progression and in connection with their effect upon the levels of attrition.

The methodology of this thesis was library and online research of primary and secondary materials. I have conducted analysis of policy documents and guidelines, police and Crown Prosecution Service (CPS) manuals, and the consequent reports on these documents in order to determine whether they are correctly implementing and achieving the goals that they have been set, and whether mental health is given sufficient consideration. A limitation of the research is that I am not a medical doctor and I do not have the medical background and knowledge of a psychiatrist. In order to address this deficit, I used a combination of academic literature and general books and online resources on mental health to supplement the gap in my knowledge.

The arguments of the thesis are based upon the empirical findings of other social scientists. I was cognisant of any accompanying biases they may have had in conducting and writing up their research findings. Some of the studies discussed have small samples and consequently the findings are not suitable for extrapolation.

The attrition studies referred to in this thesis employ the general term ‘mental health’; they do not specify the exact conditions with which complainants had been diagnosed. It is therefore unclear, for example, whether complainants with a specific condition such as depression are less likely to withdraw from the process than those with, for example, bipolar disorder. However, this highlights a gap in the literature and may be an area of possible future research. In order to address this issue I have identified the types of issues or symptoms associated with certain mental health conditions. For example, an attribute of borderline personality disorder is that an individual can appear emotionally unstable and ‘difficult’.⁷ I then speculated as to how this characteristic symptom might be taken into account as part of the relevant investigative or prosecutorial process and to related questions regarding progression of the case. Despite the limitations to this approach in that the conditions are not clearly designated, I trust that it still provides a valuable methodological step that contributes more clarity to understanding these issues as opposed to the use of the generic term ‘mental health.’ This particular point has attracted less attention in the literature and the thesis aims to fill in this gap.

Areas of exclusion

The focus of this thesis is the offence of rape as defined in section 1 of the Sexual Offences Act 2003 (SOA 2003). It does not discuss in any detail other sexual offences within the SOA 2003.⁸ This choice was made in order to closely examine the relevant issues generated by the offence of rape.

⁷ NHS Choices, ‘Borderline Personality Disorder - Symptoms’ <www.nhs.uk/Conditions/Borderline-personality-disorder/Pages/Symptoms.aspx> [accessed May 2016].

⁸ Sections 2-4 Sexual Offences Act 2003.

The SOA 2003 came into effect on 1 May 2004. This thesis considers the law for offences committed after this date. It does not discuss the position under the old law of the Sexual Offences Act 1956. The SOA 2003 made significant changes to the law governing sexual offences, the most significant of which was to the substantive offence of rape.⁹ Section 1 of the SOA 2003 prescribes that rape can be committed where the accused (A) ‘intentionally penetrates the vagina, anus or mouth of another person’ (the complainant or B) ‘with his penis’. This means that the legal definition of rape now includes oral and anal rape, thereby including male victims. The offence remains gender-specific; only a man can commit the offence. A second significant change relates to consent, which was given a statutory definition. This is set out in section 74 and defines consent as given ‘*if B agrees by choice, and has the freedom and capacity to make that choice*’. In order for an offence to be committed, the complainant’s consent must be absent. In addition, there will be no offence where the accused *reasonably believes* that the complainant is consenting.¹⁰

Although the offence of rape may be committed against a female or male victim, a highly disproportionate incidence of female victimisation over male victimisation calls for a more specific focus on cases involving female victims, or complainants.¹¹

Figures from the Office for National Statistics for the year ending March 2016 show that women were 5 times more likely than men to have experienced a form of sexual

⁹ A Ashworth and J Temkin, ‘The Sexual Offences Act 2003: Rape, Sexual Assault and the Problem of Consent’ [2004] Crim LR 328.

¹⁰ Determining whether or not the accused reasonably believed that the complainant consented requires reference to all the circumstances, including any steps that the accused has taken to ascertain whether the complainant consents. Further conclusive and evidential presumptions were drafted which related to the absence of consent and the defendant’s belief in consent. See sections 75 and 76 of the SOA 2003.

¹¹ The term ‘complainant’ rather than victim or survivor is used throughout the thesis. See discussion in C M Mardorossian, ‘Towards a New Feminist Theory of Rape’ (2002) 27(3) Signs: Journal of Women in Culture and Society 743, 764.

assault after the age of 16: 19.9% of women as compared with 3.6% of men.¹² Additionally, according to the aggregated data from the ‘Crime Survey for England and Wales’ in 2009-10, 2010-11 and 2011-12, 0.5% of females reported being a victim of rape or sexual assault by penetration in the previous 12 months. This is equivalent to around 85,000 female victims on average per year.¹³ Such figures may not be indicative of the incidence of male rape, as it has been shown men are often unwilling to report sexual victimisation.¹⁴

Further, this thesis does not examine rape in the context of historic sexual abuse, or child complainants, since both these types of cases raise unique investigative, procedural and evidential issues. There are specific guidelines and procedures in place for minors regarding both police questioning and cross-examination conducted at trial,¹⁵ and the issue of consent is often irrelevant in these cases.¹⁶ Lastly, the research considers the law as it applies to England and Wales but reference is made to other common law jurisdictions where the comparison is useful.

¹² Office for National Statistics, Focus on Violent Crime and Sexual Offences, England and Wales year ending March 2016 (Domestic Abuse, Sexual Assault and Stalking) (<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2016/domesticabusesexualassaultandstalking>) [accessed May 2017].

¹³ Ministry of Justice, Home Office & the Office for National Statistics, ‘An Overview of Sexual Offending in England and Wales: Statistics Bulletin, 6. <www.gov.uk/government/uploads/system/uploads/attachment_data/file/214970/sexual-offending-overview-jan-2013.pdf> [accessed August 2015].

¹⁴ M Scarce, *Male on Male Rape: The Hidden Toll of Stigma and Shame* (Basic Books 2001) or for entry into this area see J A Turchik, ‘Myths about male rape: A literature review’ (2012) 13(2) *Psychology of men & masculinity* 211.

¹⁵ Such guidelines include: *Achieving Best Evidence in Criminal Proceedings – Guidance on Interviewing Victims and Witnesses, and Guidance on using Special Measures*; the special measures provisions of the Youth Justice and Criminal Evidence Act 1999; the need for pre-trial ‘Ground Rules’ hearings about cross-examination of vulnerable witnesses and Judicial College Bench Checklist for Young Witness Cases. See E Henderson, ‘All the proper protections - the Court of Appeal rewrites the rules for the cross-examination of vulnerable witnesses’ [2014] *Crim LR* 93; R Marchant, ‘How Young is Too Young? The evidence of children under five in the English Criminal justice system’ (2013) *Child Abuse Review*; A Brammer and P Cooper (2011) ‘Still Waiting for a Meeting of Minds: Child Witnesses in the Criminal and Family Justice Systems’ [2011] *Crim LR* 925.

¹⁶ In relation to other offences involving children there is no requirement to prove absence of consent – only the actus reus of the offence and the age of the child needs to be proved. This applies to the offences of: rape of child under 13 contrary to s 5; child sexual offences involving children under 16 contrary to ss 9-15; and children under 18 having sexual relations with persons in a position of trust contrary to ss 16-19 SOA 2003.

Context and scope of research

This thesis is concerned with how the presence of mental health issues affects the procedural decisions of the police and Crown Prosecution Service (CPS), which, in turn, affect case progression. Rape complainants with mental health issues face particular barriers regarding the believability and credibility of their claims. This thesis builds upon the premise that an allegation of rape by a complainant with a mental health condition is more likely to drop out of the criminal justice process. It will examine the extent to which this happens, how it happens and why it happens. The studies discussed throughout this thesis and often cited in footnotes, provide the basis for the analysis of this attrition.

This introductory chapter sets out the context for the research, establishes the key themes that run throughout the thesis, and defines terms that will be employed throughout. Recent governmental and prosecutorial reforms placing victims at the centre of the criminal justice process will be considered in the context of rape allegations and the difficulties faced by complainants with mental health issues.

The research examines the scale of victimisation – that is, the percentage of individuals with mental health issues who are victims of crime in this area and sets out some of problems identified in the literature. Studies show people with a mental health issue are more likely to be a victim (rather than a perpetrator) of a criminal offence than those without a mental health issue. Additionally, in regards to gender and mental health, a woman is more likely to be a victim of a sexual assault, and/or suffer from more than one attack.¹⁷ This means that a complainant with mental health issues is more likely to be a victim of offending but will find it harder to

¹⁷ Department of Health, *No Health without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of All Ages* (London HM Government 2011) 61.

report the allegation of rape to police. These problems concern the initial stage of reporting where the decisions made by the complainant are crucial. Further problems arise later in the process with regard to police and CPS decision-making, and these are the subject of subsequent chapters.

This chapter discusses the correlation between mental health (as a type of complainant vulnerability) and the rate of attrition in England and Wales. Results from key attrition studies on rape suggest that mental health issues negatively influence case progression, causing further attrition in the number of rape cases that are able to result in a successful prosecution. To establish the context, we will first examine the increased focus on the victim in the criminal justice system in England and Wales.

Increased focus on the victim in criminal justice context

In both theory and practice, the investigation and prosecution of criminal offences has been shifting towards a more victim-centred approach since the 1990s. This change is evidenced in the production of legislation and policy documents which outline the need for additional or better support for victims of crime.¹⁸ A recurring objective of such government policy has been the need to protect the most vulnerable in society to keep such persons free from harm and to ensure that their rights are respected.¹⁹ This policy has involved investigating the barriers to justice and trying to protect vulnerable adults, including those with mental health problems, to ensure

¹⁸ Home Office, *Justice for All* (Cmd 5563, 2002), Ministry of Justice, *Getting it Right for Victims and Witnesses* (Ministry of Justice 2012), Home Office, *Getting it Right for Victims and Witnesses: The Government Response* (Cm 8397, 2012), Home Office, *The Code of Practice for Victims of Crime* (Home Office 2015), J Jackson, 'Just for All: Putting Victims at the Heart of Criminal Justice?' (2003) 30(2) *Journal of Law and Society* 309, Ministry of Justice, *Transforming the CJS Strategy and Action Plan* (Ministry of Justice, 2013).

¹⁹ *Access to Justice: A review of the existing evidence of the experiences of adults with mental health problems* (Ministry of Justice Research Series 06/09, 2009) 1.

crimes are identified, prosecuted and prevented.²⁰ These investigations have resulted in reports like *No Secrets*²¹ and *Speaking up for Justice*.²² The latter report, published by the Home Office, set out 78 recommendations intended to improve the treatment of vulnerable and intimidated witnesses. Some of these recommendations were implemented in the form of the Youth Justice and Criminal Evidence Act 1999 (YJCEA 1999), which created special measures to assist the witness in giving his/her best evidence in court.²³

Another critical document is the *Code of Practice for Victims of Crime*, a statutory code based on the concept of victims acquiring certain ‘service rights’ in addition to the procedural rights created by the YJCEA 1999. These rights relate to the provision of information about case progression and other matters unrelated to procedure. The Code outlines the minimum level of service that victims are entitled to receive from criminal justice agencies.²⁴ An example of such a measure is the ‘explanatory letter’, delivered in person to the complainant when a case is discontinued or a charge reduced. The Victims’ Right of Review Scheme also grants victims of rape the right to request a review of a CPS decision not to prosecute or to terminate criminal proceedings. The *Code of Practice for Victims of Crime* also introduced Witness Care Units intended to manage the care of witnesses and victims from the point of charge through to the conclusion of a case and provide better information and support to victims of crime, especially in regards to vulnerable victims and

²⁰ A Sanders et al., *Victims with learning disabilities: Negotiating the criminal justice system* (Centre for Criminological Research, University of Oxford 1997).

²¹ Department of Health, *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health 2000).

²² Home Office, *Speaking up for Justice: Report of the Home Office Interdepartmental Working Group on the Treatment of Vulnerable or Intimidated Witnesses in the Criminal Justice System* (London, Home Office 1998).

²³ See sections 16-33 of the Youth Justice and Criminal Evidence Act 1999.

²⁴ Pursuant to section 33 of the Domestic Violence, Crime and Victims Act 2004. The most recent version of the Code was published in October 2015.

witnesses.²⁵ These are some of the critical foundational documents which set out to put the victim at the centre of the criminal justice process.²⁶

During the same period, in the context of sexual offences, the treatment of rape complainants has also garnered attention.²⁷ There have been many governmental and prosecutorial initiatives designed to alleviate the stress of involvement in the criminal justice process. In the context of police response to rape and the treatment of victims, examples of reforms in this area include an increased use of specially trained officers, police use of early evidence kits,²⁸ and better access for complainants to Sexual Assault Referral Centres. Other measures designed to improve the complainant's experience include: an automatic presumption of eligibility for special measures; an entitlement to anonymity in the media²⁹; and the deployment of Independent Sexual Violence Advisors (ISVAs), who provide professional support to complainants throughout the entire pre-trial and trial process. Despite such reforms, some critics have expressed doubt as to whether there has

²⁵ C Hoyle and L Zedner, 'Victims, Victimisation and Criminal Justice' in M Maguire, R Morgan and R Reinder (eds) *The Oxford Handbook of Criminology* (OUP 2007); Home Office, *Early Special Measures Discussions between Police and the Crown Prosecution Service* (London: Home Office 2009).

²⁶ For a discussion of 'putting the victim at the heart of the criminal justice system' see M Hall, 'The relationship between victims and prosecutors: defending victims' rights?' [2010] Crim LR 31, D Jones and J Brown, 'The relationship between victims and prosecutors: defending victims' rights? A CPS response' [2010] Crim LR 212.

²⁷ HMCPSI/HMIC, *A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape: a CPSI and HMIC joint thematic inspection* (HMCPSI, April 2002); HMIC and HMCPSI, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSI, 2007), HMIC and HMCPSI, *Forging the links: Rape investigation and prosecution: A joint review by HMIC and HMCPSI* (February 2012) V Stern, *A Report by Baroness Vivien Stern CBE of An Independent Review into How Rape Complaints are Handled by Public Authorities in England and Wales* (London: Home Office 2010).

²⁸ HMIC/HMCPSI, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSI 2007), *Forging the links: rape investigation and prosecution: a joint review by HMIC and HMCPSI* (HMIC/HMCPSI 2012), Joint CPS and Police Action Plan on Rape (April 2015) <www.cps.gov.uk/publications/equality/vaw/rape_action_plan_april_2015.pdf> [accessed Nov 2016].

²⁹ Sexual Offences Amendment Act (1976) s 4. See however, the naming of Ched Evan's accuser online and the problem of complainant identification on social media: S Morris, 'Social media naming of Ched Evan's accuser raises legal questions', *The Guardian* (14 October 2016) <www.theguardian.com/law/2016/oct/14/social-media-naming-of-ched-evans-accuser-raises-questions-law>

been meaningful change when it comes to rape law reform and treatment of complainants.³⁰ Some of the criticisms include that public attitudes towards rape remain unchanged and that there are problems of implementation.

To understand the position of a complainant with mental health issues, it is important to place these complainants within the current policy framework on treating victims and especially victims of sexual offences. Following reports such as the *Rape Experience Review*³¹, where a 'victim focused' approach was recommended, there has been an increased emphasis on believing the complainant's allegation, starting from the initial reporting stage, and supporting the complainant to remain a willing participant in the criminal justice process.³² However, despite these reforms, certain vulnerable complainants continue to be disadvantaged due to their perceived lack of credibility as a witness.³³ This may be seen in attitudes of suspicion or disbelief that criminal justice stakeholders hold about whether complainants are 'genuine' victims of rape.³⁴

³⁰ K Cook, 'Rape investigation and prosecution: stuck in the mud?' (2011) 17 *Journal of Sexual Aggression* 250, 257, J Brown, 'We mind and we care but have things changed? Assessment of progress in the reporting, investigating and prosecution of allegations of rape' (2011) 17 *Journal of Sexual Aggression* 1, A Carline and C Gunby, 'Rape Politics, Policies and Practice: Exploring the Tensions and Unanticipated Consequences of Well-Intentioned Victim-Focused Measures' (2017) 56(1) *Howard Journal of Criminal Justice* 34.

³¹ S Payne, *Redefining Justice: Addressing the individual needs of victims and witnesses* (London Home Office, 2009).

³² For example, in the HMIC's report on crime recording it states 'the presumption that the victim should always be believed should be institutionalised'. HMIC, *Crime-Recording: Making the Victim Count, The final report of an inspection of crime data integrity in police forces in England and Wales* (November 2014) <www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/crime-recording-making-the-victim-count.pdf>

An earlier Police Special Notice from 2002 set out the principles of rape investigation and stated that 'it is the policy of the Metropolitan Police Service to accept allegations made by the victim in the first instance as being truthful' (11/02).

³³ E Williams, J Norman and D Wunsch, 'Too Little Too Late: Assessing Vulnerability' (2009) 3(4) *Policing* 355.

³⁴ S Lees, *Carnal Knowledge: Rape on Trial* (2nd edn, Women's Press) S Lee and J Gregory, *Policing Sexual Assault* (Routledge 1999) J Jordan, *The Word of a Woman? Police, Rape and Belief* (Palgrave MacMillan 2004) E Finch and V Munro, 'Juror Stereotypes and Blame Attribution in Rape Cases involving Intoxicants' (2005) 45 *Brit J Criminol* 25.

In addition to the misgivings regarding the investigation and prosecution of rape allegations and treatment of complainants, concerns have also been expressed about the treatment of complainants who have a history or current diagnosis of mental illness.³⁵ These complainants present particular challenges to the criminal justice process. Their circumstances present additional barriers to both informing the police of the allegation and to assessments of credibility. These barriers can be compounded by cultures of scepticism and victim blaming.³⁶

In 2009, the Ministry of Justice conducted a review to investigate how adults with mental health issues experienced criminal justice.³⁷ The review found that adults with mental health issues are more at risk of becoming victims of crime than the general population, echoing findings from other research in this area.³⁸ There are also ‘risk factors’³⁹ associated with mental health issues, including homelessness, substance misuse and a history of offending which can increase the risk of becoming

³⁵ Mind, *Another Assault* (London: Mind, 2007), Pettitt B et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

³⁶ L Ellison, V Munro, K Hohl and P Wallang, ‘Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation’ (2015) 15(2) *Criminology & Criminal Justice* 225, M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan 2009), J Temkin and Krahé B, *Sexual Assault and the Justice Gap: A Question of Attitude* (Hart Publishing 2008); L Kelly, J Lovett and L Regan L, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

³⁷ *Access to Justice: A review of the existing evidence of the experiences of adults with mental health problems* (Ministry of Justice Research Series 06/09, 2009). In the same year the Department of Health published a similar review focusing on offenders: K Bradley, *The Bradley Report: Lord Bradley’s Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System* (London: Department of Health, 2009).

³⁸ L Teplin et al., ‘Crime Victimization in adults with severe mental illness – Comparison with the national crime victimisation survey’ (2005) 62(8) *Archives of General Psychiatry* 911, J S Brekke et al., ‘Risk for individuals with schizophrenia who are living in the community’ (2001) 51 *Psychiatric Services* 1358, P Fitzgerald et al., ‘Victimisation of patients with schizophrenia and related disorders’ (2005) 39(3) *Australian and New Zealand Journal of Psychiatry* 169, M Burton and A Sanders, *An evaluation of the use of special measures for vulnerable and intimidated witnesses* (Home Office 2006), B Hamlyn et al., *Evidence from surveys of vulnerable and intimidated witnesses* (Home Office RDS 2004), M Guggisberg, ‘The interconnectedness and causes of female suicidal ideation with domestic violence’ (2006) 5(1) *Australian e-Journal for the Advancement of Mental Health*.

³⁹ Defined in the report as a ‘factor associated with an increased likelihood of certain outcomes being realised’.

a victim of crime.⁴⁰ Additionally, persons with mental health issues experience discrimination and prejudice that can deter them from revealing mental health problems, reporting incidents to the police, or seeking advice or support for fear of the consequences. This highlights how complainants with mental health issues find it difficult to enter into criminal justice proceedings at all, let alone obtain a successful prosecution for their complaint. These difficulties are compounded in rape cases making this thesis all the more relevant and an important contribution to sexual offences reform.

Key terms and definitions: mental health

This chapter provides key definitions and explains terminology used throughout this thesis. The term ‘mental health’ incorporates a wide range of terms and concepts; although it is a very broad term it is used for the most part throughout the literature. It can include psychiatric evidence whereby mental health is used in a medical sense, but can also be employed in instances where a rape complainant seeks counselling due to mental distress for example. In general, courts in England and Wales are guided by the Mental Health Act 1983 (MHA 1983) whereby s1(2) provides that “‘mental disorder’ means any disorder or disability of the mind.”⁴¹ Persons who suffer from a mental disorder within the meaning of the MHA 1983 are classified as vulnerable and intimidated witnesses.

Other commonly used terms in this area include ‘mental health difficulties’ or ‘mental distress’. Ellison and Munro use ‘psychosocial disabilities’ to refer to

⁴⁰ M Theriot and S Segal, ‘Involvement with the criminal justice system among new clients at outpatient mental health agencies’ (2005) 56(2) *Psychiatric Services* 179, C T Sheldon et al., ‘Social disadvantage, mental illness and predictors of legal involvement’ (2006) 29(3) *International Journal of Law and Psychiatry* 249, G Green and N South, ‘Court based psychiatric assessment: case for an integrated diversionary and public health role (2005) 16(3) *Journal of Forensic Psychiatry and Psychology*.

⁴¹ S1 MHA 1983 as amended by the Mental Health Act 2007 (Commencement No.7 and Transitional Provisions) Order 2008.

persons who have experience of mental health problems and/or identify as mental health service users and employ this term to discuss mental health issues in relation to rape complainants.⁴² The underlying intention of using the term ‘psychosocial disabilities’ is to highlight, or adhere to, a social rather than medical model of conditions and experiences often labelled as ‘mental illness’. In the realm of mental health there are multiple factors – procedural, societal, attitudinal and environmental – which can all interact to affect rape complainants. Using ‘psychosocial disabilities’ recognises the fact that both internal and external factors can affect a complainant’s individual situation.⁴³

Mind, the leading mental health charity for England and Wales, uses the umbrella term ‘mental health’ but utilises various sub-categories. The CPS employs a similarly broad term, ‘mental health issue’, intended to avoid the use of the word ‘problem’ and its negative connotations. This thesis will use ‘mental health’ because the term’s wide-ranging nature encompasses the medical spectrum of mental health conditions, illnesses, and experiences, and also counselling or therapy, which is not purely medical, but incorporates a social aspect or concept. Furthermore, it assumes mental health conditions exist along a continuum; that every individual will experience a condition differently due to his/her unique personal circumstances, and that environmental, cultural and social factors are influential upon the nature of a condition. However, this thesis has chosen not to address, in detail, the effect that social and environmental factors or other variables have on a complainant’s mental health, and can only acknowledge that it is influential.

⁴² This is the term used by the World Network and Users and Survivors of Psychiatry, an international organising focusing upon mental health and social justice issues.

⁴³ L Ellison and V Munro, ‘Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation’ 15(2) (2015) *Criminology and Criminal Justice* 225 citing M Oliver and C Barnes, *The New Politics of Disablement* (Palgrave Macmillan 2012).

This thesis will consider cases where complainants either:

- i) exhibit a pre-existing mental health issue or condition
- ii) exhibit mental health issues arising as a result of the rape

A pre-existing mental health issue is likely to be more pertinent to analysis of the early stages of police investigation, for example, how the complainant appears to the police or the nature of the account given during interview. Although the complainant may exhibit symptoms of trauma during the interview that are consistent with mental health issues, any pre-existing condition will usually emerge as the prosecution builds its case. The prosecution also considers any counselling a complainant has received. At trial, both the complainant's medical and counselling records may be relevant.

A detailed analysis of a specific mental health condition and its symptoms, will take place in Chapter 2. Further chapters will examine the type of material relating to the complainant's mental health which the police and CPS deal with as part of the investigation and prosecution. These materials can include medical records, psychological or psychiatric reports, and records held by local authorities such as social services or educational departments. The research will examine how such material has a bearing on the progression or non-progression of a case.

The scale of victimisation of complainants with mental health issues: figures and statistics

It is notable that there are no routine recording processes designed to identify the number of complainants who have a mental health issue when a report is first made to the police. However, there is evidence to suggest that adults with pre-existing mental health issues are at a disproportionately greater risk of victimisation when

compared to the general population.⁴⁴ Studies focusing on violent offences against the person suggest that individuals with a mental health condition have a heightened risk of victimisation and are therefore more vulnerable as compared with the general population, especially in instances where the mental health issue is severe.⁴⁵ Here ‘vulnerability’ refers to the likelihood of becoming a victim of crime, or the presence of certain factors that render the person more susceptible to harm. For instance, men with mental health issues are more likely to be victims of physical assault, women of sexual offences.⁴⁶

Mind has also carried out research in this area, finding that individuals with mental health issues were at a higher risk of being targeted for criminal offences, including rape and sexual offences. Their 2007 survey of more than 300 people living with mental illness in England and Wales found that 71% had been the victim of crime at least once in the past two years. 34% of respondents had been the victim of theft or financial crime, 22% had been physically assaulted, and 10% had been sexually assaulted, often by someone personally known to the victim.⁴⁷

⁴⁴ K McKracken, A Perry and C Phillips, *Access to Justice: A Review of Existing Evidence of the experiences of Adults with Mental Health Problems* (Ministry of Justice Research Series 06/09, 2009); R Maniglio, ‘Severe mental illness and criminal victimisation: a systematic review’ (2009) 119(3) *Acta Psychiatrica Scandinavica* 180; H Khalifeh and K Dean, ‘Gender and violence against people with severe mental illness’ (2010) 22(5) *International Review of Psychiatry* 535; H Khalifeh, et al., ‘Violence against People with Disability in England and Wales: Findings from a National Cross-Sectional Survey’ (2013) 8(2) *PLoS ONE*, C Sin et al., *Disabled People’s Experiences of Targeted Violence and Hostility, Research Report 21* (London: Equality and Human Rights Commission, 2009), L Teplin et al., ‘Crime victimisation in adults with severe mental illness’ (2005) 62(8) *Archives of General Psychiatry* 911.

⁴⁵ J Brekke, C Prindle, S Bae and J Long, ‘Risks for individuals with schizophrenia who are living in the community’ (2001) 52(10) *Psychiatric Services* 1358, V Hiday, M Swartz and J Swanson, ‘Criminal Victimization of Persons with Severe Mental Illness’ (1999) 50(1) *Psychiatric Services* 62, E Walsh et al., ‘Prevalence of Violent Victimization in Severe Mental Illness’ (2003) 183 *British Journal of Psychiatry* 233, L A Teplin et al., ‘Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey’ (2005) 62(8) *Arch Gen Psychiatry* 911.

⁴⁶ H Khalifeh and K Dean, ‘Gender and violence against people with severe mental illness’ (2010) 22(5) *International Review of Psychiatry* 535; H Khalifeh, L M Howard, D Osborn, P Moran and S Johnson, ‘Violence against People with Disability in England and Wales: Findings from a National Cross-Sectional Survey’ (2013) 8(2) *PLoS ONE*

⁴⁷ Mind, *Another Assault* (London: Mind 2007).

The 2014 report co-authored by Pettitt et al., *At Risk, Yet Dismissed: The Criminal Victimization of People with Mental Health Problems*, revealed similar levels of victimisation in a London-based study of 361 people with severe mental illness (SMI).⁴⁸ It found that 45% of respondents had been victims of crime in the past year, compared with 16% of London residents in general. Women reported high rates of sexual violence: 42% of women surveyed had been a victim of rape or attempted rape in adulthood; 10% had been a victim of a sexual assault in the past year.⁴⁹ Findings from other studies also highlight how women with an SMI are at a higher risk of rape or sexual assault.⁵⁰

This research shows that the victimisation of individuals with mental health issues is a complex and multi-faceted problem. It shows higher rates of victimisation, but also an increased likelihood of the individual becoming a target of such crime. In Pettitt's study, persons with an SMI were up to four times more likely to be victimised by their relatives or acquaintances than those from the general population.⁵¹ In fact:

[m]any participants felt that having a mental health problem was a factor in their victimisation. They gave examples of perpetrators picking up on visible signs of vulnerability and distress, and known perpetrators preying on them when they were unwell and less able to protect themselves. Some felt perpetrators targeted them because they understood that people

⁴⁸ 'SMI' refers to people with any mental health diagnosis who had been under the care of community mental health teams for one year or longer.

⁴⁹ B Pettitt, S Greenhead, H Khalifeh, et al., *At Risk Yet Dismissed: The Criminal Victimization of People with Mental Health Problems* (Victim Support/Mind 2013) 19.

⁵⁰ H Khalifeh and K Dean, 'Gender and violence against people with severe mental illness' (2010) 22(5) *International Review of Psychiatry* 535–546; H Khalifeh et al., (2013) 'Violence against people with disability in England and Wales: Findings from a national cross-sectional survey' 8(2) PLoS ONE.

www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0055952.

⁵¹ B Pettitt, S Greenhead, H Khalifeh, et al., *At Risk Yet Dismissed: The Criminal Victimization of People with Mental Health Problems* (Victim Support/Mind 2013) 4.

with mental health problems are more easily discredited and commonly disbelieved when they report.⁵²

Researchers also reported a high risk of *repeat* victimisation amongst persons with a SMI. 45% had experienced more than one type of crime in the past year.⁵³ Taking into account demographics, social deprivation and area characteristics, it remained the case that people with an SMI were found to be five times more likely to be a victim of an assault than the general population. Women with an SMI were 10 times more at risk as compared with the general population.⁵⁴

Nevertheless, it is not simply the fact of a mental health diagnosis that generates this increased risk of victimisation, rather there seems to be a range of contextual factors for those with mental health issues which increases vulnerability. Such factors include low income, lack of secure housing or employment, history of childhood abuse and a history or current problem with drug or alcohol abuse,⁵⁵ though it is acknowledged that these are common to lots of victims of crime. This echoes Ellison and Munro's choice of definition of 'Psychosocial Disability' to reflect the related social and environment factors inherently associated with mental health. Elements that contribute to the increased risk of sexual victimisation for those with mental health issues can therefore be viewed in very broad terms. For example, these include lack of access to resources and information as compared to the general

⁵² Ibid

⁵³ Ibid. Studies from other jurisdictions also indicate that complainants with mental health issues are at a higher risk of victimisation, see: B Chapple et al., 'Correlates of victimisation amongst people with psychosis' (2004) 39(10) *Social Psychiatry and Psychiatric Epidemiology* 836, P Fitzgerald et al., 'Victimisation of Patients with Schizophrenia and Related Disorders' (2005) 39(3) *Australian and New Zealand Journal of Psychiatry* 169.

⁵⁴ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

⁵⁵ L Goodman, M Dutton and M Harris M, 'Episodically homeless women with serious mental illness: Prevalence of physical and sexual assault' (1995) 65(4) *American Journal of Orthopsychiatry* 468-478. Similar findings are discussed in C Hart et al., 'A UK population-based study of the relationship between mental disorder and victimisation' (2011) 47(10) *Social Psychiatry and Psychiatric Epidemiology* 1581.

public, powerlessness, and others making decisions on their behalf.⁵⁶ Therefore, a person's 'vulnerability' to crime is often a complex mixture of interrelated factors.

Further complexity is presented by a lack of official data on criminal victimisation amongst this group, which means that the available studies can only provide a snapshot of this area. Nevertheless, these studies do provide a starting point for research into the link between mental health and victimisation, and patterns and themes can be gleaned from the research data. Clearly, there is a need for a better response: the figures indicate that rape complainants with mental health issues are at a much higher risk of victimisation.

Difficulties and fear of reporting rape to police

Statistics indicate that the vast majority of rape complainants do not come forward to report an allegation – the figure is approximately 89%.⁵⁷ When an individual with mental health issues is the victim of a sexual offence she is faced with particular difficulties when informing the police of the alleged crime. The rates of reporting in crimes committed against people with mental health issues is also troubling in cases of rape or sexual assault. In Mind's 2007 survey, 30% of victims of a crime told no one what had happened to them. In Pettitt's research, a third of complainants did not disclose their experiences of being a victim of crime to any professional. In the case of sexual assault, half the female victims and 70% of male victims did not disclose their experiences to anyone.⁵⁸

⁵⁶ M Crossmaker, 'Behind locked doors – institutional sexual abuse' (1991) 9(3) *Sexuality and Disability* 201, 204.

⁵⁷ Ministry of Justice, Home Office and Office of National Statistics, *An Overview of Sexual Offending in England and Wales*, Statistics Bulletin (Ministry of Justice, London 2013) 7 <www.gov.uk/government/publications/an-overview-of-sexual-offending-in-england-and-wales>

⁵⁸ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013) .

The literature suggests that there are many reasons why a complainant may be reluctant to report a rape to the police, but in addition to self-blame, shame and pressure from immediate and extended family, many involve fear: fear of violence, intimidation, embarrassment, and a fear of going to court and of the court process.⁵⁹ Another recurring reason given is a fear of *not being believed* by the police and that the rape will not be characterised as such.⁶⁰ Although those with mental health issues often have these fears compounded, such obstacles affect rape complainants in general.⁶¹

The failure to report a rape allegation was considered specifically in Mind's 2007 survey of victims with mental health conditions. *Another Assault* made note of the additional and substantial barriers to reporting by complainants with mental health issues. Survey responses explained feeling reluctant to report allegations to police and were wary of police contact. Reasons given included previous negative experiences of reporting and/or detention by the police, particularly under 'place of safety' powers.⁶² A perception of a lack or low understanding of mental health issues amongst police officers meant that those surveyed felt unsure as to whether their allegations would be taken seriously or whether they would be treated with respect. Some described an unwelcoming and dismissive police response following disclosure of their diagnosis. Over a third of respondents felt the police treated them less favourably due to mental health issues.⁶³ Similar views were reflected in Pettitt's

⁵⁹ L Kelly et al., *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005), A Myhill and J Allen, *Rape and Sexual Assault of Women: Findings from the British Crime Survey, Home Office Research Findings 159* (London: Home Office 2002).

⁶⁰ Ibid.

⁶¹ J Jordan, 'Worlds Apart? Women, Rape and the Police Reporting Process' (2001) 41 *Brit J Criminol* 679.

⁶² Section 136 Mental Health Act 1983. This section allows the police to take the complainant to a place of safety from a public place for a mental health assessment. Section 135 concerns being taken to a place of safety from a private place. It is also known as being 'sectioned.'

⁶³ Mind, *Another Assault* (Mind, 2007).

study which found that victims with mental health issues who had previously reported offences indicated that they would not report allegations to the police in future due to poor previous experiences.⁶⁴

These reports indicate that complainants are fearful of both the police and of investigative processes; further, they are reluctant to disclose to police that they suffer from a mental health condition. Evidence suggests that some complainants elect to remain silent and tell no one about their victimisation due to a fear that police or others could misconstrue the allegation as a sign of deteriorating mental health, which might lead to unwanted medical intervention.⁶⁵ For many with an SMI, the consequences of medical intervention of this nature could include being sectioned and/or other serious repercussions, such as the loss of access to children. Others fear being blamed for an incident and any negative ramifications that this may have for the care or services they receive in the community.⁶⁶

In other research, complainants have expressed concerns about the later stages of the criminal justice process, particularly with regards to what will take place at trial. This includes fear of, or concern about, being questioned about their medical and psychiatric health and being subsequently discredited by that mental health history.⁶⁷

The prospect of an invasive cross-examination based on psychiatric or medical

⁶⁴ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

⁶⁵ S Koskela, B Pettitt and V M Drennan, 'The experiences of people with mental health problems who are victims of crime with the police in England: A Qualitative Study' (2016) 56 *Brit J Criminol* 1014, 1020.

⁶⁶ Mind, *Another Assault* (2007), Pedlar M, Baker S, Williams C, George S, *Silenced Witnesses* (London: Mind 2000), S Koskela, B Pettitt and V M Drennan, 'The experiences of people with mental health problems who are victims of crime with the police in England: A Qualitative Study' (2016) 56 *Brit J Criminol* 1014.

⁶⁷ C A Colarusso, *The Psychiatric Witness in Court: What Mental Health Professionals need to know* (Rowman & Littlefield Publishers, 2014) Chapter 9: 'a survey of the legal literature: how judges & lawyers think about the role of mental health professionals involvement in the legal system', 283.

records also has potential to make a detrimental impact on mental health.⁶⁸ This relates to the general toll that participation in criminal proceedings could have on their mental well-being.⁶⁹ Ellison and Munro note how this can create difficulties for rape complainants generally, especially when they do not receive sufficient support as vulnerable witnesses. For complainants with mental health issues this is especially challenging, whether due to a greater risk (or greater perception of risk) of seeing one's case fail to progress, or a failure to provide and lack of appreciation for the need for additional support and assistance.⁷⁰

The above discussion highlights how complainants with mental health conditions experience higher levels of victimisation as compared with the general population. These complainants not only struggle to report an allegation of rape to the police, but where they do report the allegation they face additional obstacles both associated with their mental health condition, and in reporting that condition to police. The next section considers the relationship between a complainant with mental health condition and that complainant's case failing to progress through the criminal justice system.

The relationship between mental health and attrition

Attrition refers to the process whereby a case 'drops out' from the criminal justice system and therefore does not result in a conviction.⁷¹ While all crimes may 'drop out' of the process, there are consistently high levels of attrition in rape cases; a

⁶⁸ M Pedlar, S Baker, C Williams, S George, *Silenced Witnesses* (London: Mind 2000), B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013)

⁶⁹ M Pedlar M, et al. *Silenced Witnesses* (MIND 2000); CPS, *Supporting Victims and Witnesses who have Mental Health Issues* (2009).

⁷⁰ L Ellison and V Munro, 'Challenging Criminal Justice? Psychosocial disability and rape victimisation' 15(2) (2015) *Criminology and Criminal Justice* 225, 230.

⁷¹ L Kelly, J Lovett and L Regan L, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005) 7.

source of concern and the focus of much policy consideration and research over the past 20 years.⁷²

There are various possible attrition stages, or ‘exit points’, located during the police investigation, CPS prosecution and trial stages.⁷³ One of the key attrition stages is the very first; whether the police record the report of an allegation as a crime or ‘no crime’.⁷⁴ If recorded as a crime, the police may yet decide to take no further action due to insufficient evidence. If they do proceed, the case is referred to the CPS for charging. Following a referral, the CPS must decide whether to prosecute the defendant or take no further action. This decision is made by application of the *Code for Crown Prosecutors*. The *Code* contains two tests: an evidential sufficiency test, whereby prosecutors must be satisfied that there is a realistic prospect of conviction; and a public interest test, which requires prosecutors to consider whether a prosecution is needed on this ground.⁷⁵ The last attrition stage is at the point a case reaches court, when the jury must determine whether the prosecution has proven the

⁷² S Grace, C Lloyd and L Smith, *Rape: From Recording to Conviction* (Research and Planning Unit Paper 71, Home Office 1992), J Harris and S Grace, *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s*, Home Office Research Study 196 (HMSO: London 1999), HMCPSI/HMIC, *A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape: a CPSI and HMIC joint thematic inspection* (HMCPSI, April 2002), L Kelly, Lovett J and Regan L, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005), S Lea et al, *Attrition of Rape Cases: Developing a Profile and Identifying Relevant Factors* (2003) 43(3) *Brit J Criminol* 583, V Stern, *A Report by Baroness Vivien Stern CBE of An Independent Review into How Rape Complaints are Handled by Public Authorities in England and Wales* (London: Home Office 2010).

⁷³ S Lea, U Lanvers and S Shaw, ‘Attrition in Rape Cases: Developing a Profile and Identifying Relevant Factors’ (2003) 43(3) *Brit J Criminol* 583, S Lees and J Gregory, ‘Attrition in Rape and Sexual Assault Cases in England and Wales’ (1996) 36 *Brit J Criminol* 1.

⁷⁴ ‘No Crime’ is where additional verifiable information that determines that no crime occurred becomes available to the police. In 2014, restrictions were put in place for instances where a police officer is able to ‘no crime’ a report of rape.

⁷⁵ CPS, *The Code for Crown Prosecutors*

www.cps.gov.uk/publications/code_for_crown_prosecutors/codetest.html [accessed Feb 2017].

elements of the offence beyond a reasonable doubt.⁷⁶ An acquittal is the ultimate attrition point.

The following figure sets out these attrition points in the criminal justice process.

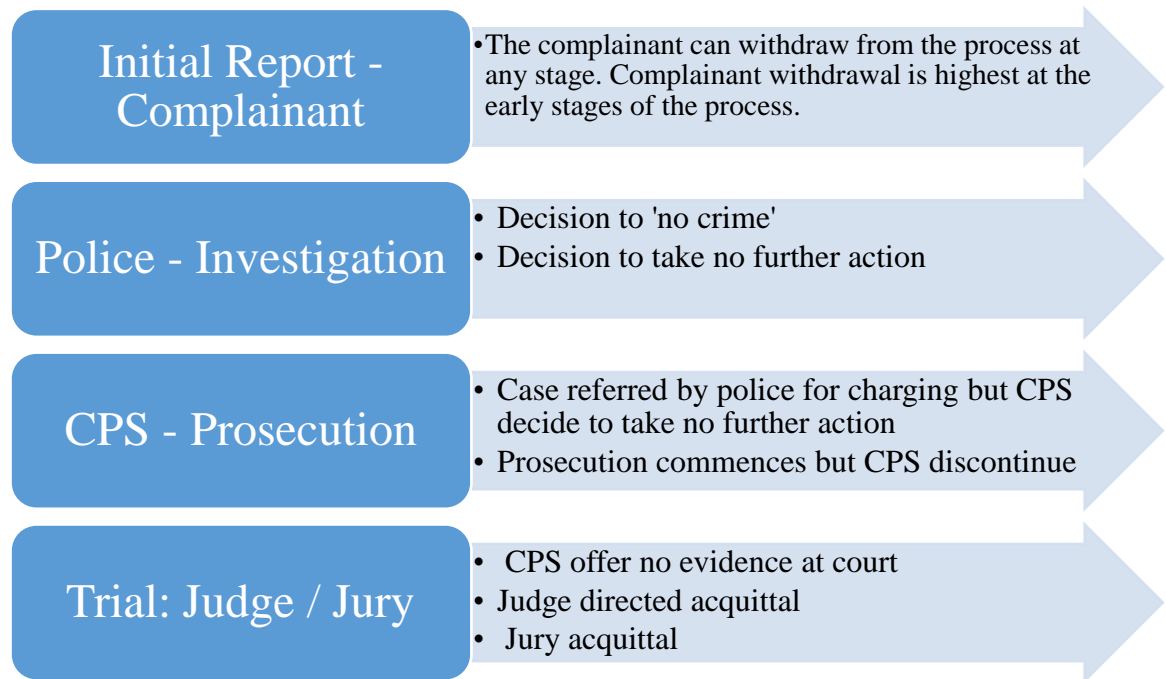


Figure 1: Attrition Points in the Criminal Justice Process.

The complainant's decision not to report the rape to the police represents the first attrition point in the criminal justice process.⁷⁷ However, this thesis does not consider non-reporting of the offence as an attrition point. This is because the allegation has not entered the official crime recording system.⁷⁸ The exact figures of those who decide not to report the rape are unknown, although the number is thought to be around 89%.⁷⁹ The complainant's decision to report the rape to the police is the first step in the legal process and one of the few steps, excluding a decision to

⁷⁶ L Ellison, V Munro, K Hohl and P Wallang, 'Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation' (2015) 15(2) *Criminology & Criminal Justice* 225, 231.

withdraw the complaint, that the complainant may take herself.⁸⁰ Once the rape is reported to the police, the complainant's role becomes one of victim/witness and it is the police, or if the case progresses, the CPS, who take responsibility for the progression or non-progression of the case. At this stage, attrition can occur for a number of reasons and is influenced by a range of factors including: failure to identify the perpetrator, complainant withdrawal, the police decision to take no further action or the CPS deciding not to proceed with the case. There are also reciprocal relationships between the various stages of attrition, for example the CPS may advise the police not to continue with the case at the investigative stage. This means that attrition at each stage should be understood within the context of other stages or parties. It is noteworthy that the investigative stage is where most attrition occurs; between half and two thirds of cases are withdrawn following entrance to the criminal justice process.⁸¹

Figures from the CPS *Violence against Women and Girls 2015-16 Crime Report* (VAWG) state that the volume of rape referrals from the police to the CPS was 6,855 in 2015-16. This is an increase of 696 referrals (11.3%) on the volume of 6,159 in 2014-15. Of all unsuccessful outcomes in rape cases, the proportion of jury acquittals fell slightly in 2015-16 to 61.4% from 62.7% in 2014-15.⁸² There are many possible reasons for unsuccessful outcomes. The case may be discontinued by the CPS following an initial decision to charge. Attrition may be due to victim issues, judge

⁸⁰ C Hanly, D Healy and S Scriver, *Rape and Justice in Ireland: A National Study of Survivor, Prosecutor and Court Responses to Rape* (Liffey Press 2009) 47.

⁸¹ HMCPS & HMIC, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSI, 2007); L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

⁸² The CPS report defines an unsuccessful prosecution as where the defendant is not convicted. CPS data on successful rape prosecutions includes not only cases resulting in a conviction for rape, but also cases initially flagged as rape where a conviction was obtained for an alternative or lesser offence. In contrast, the Ministry of Justice data concerns only convictions of cases charged and convicted for rape.

directed acquittal or an acquittal following trial. In regards to victim issues, this can include victim retraction, non-attendance, or that a victim's evidence does not support the case. The next section will examine instances of 'unsuccessful prosecution', which is another way of describing attrition, as affecting or relating to complainants with mental health issues, and the existing procedures in place.⁸³

Findings from key attrition studies on rape in the UK

This section is an outline of key attrition studies on rape in the England and Wales and their findings, with particular reference to mental health and the link between the presence of a mental health issue in the complainant and the rate of attrition.

Harris and Grace's research is the earliest UK study on attrition which makes reference to rape complainants with mental health issues. They investigated 483 rape cases reported in a single year, following their progress through the criminal justice process.⁸⁴ In terms of attrition, approximately one quarter of cases were labelled 'no crime', a third were 'no further action'. Only 6% of cases originally recorded by the police as rape resulted in convictions for rape. The rate of attrition for cases involving complainants with mental health issues was not specifically examined, however, the authors recorded that 40 cases that were discontinued by the police involved complainants who had learning disabilities or were mentally disordered.⁸⁵

This level of discontinuance highlights the significance of the problem in this area.

A subsequent study by Lea et al. reported a very high rate of attrition in cases where the alleged rape involved a victim with learning disabilities, psychiatric problems or

⁸³ CPS, Violence against Women and Girls 2015-16 Crime Report (2016) 49
www.cps.gov.uk/publications/docs/cps_vawg_report_2016.pdf

⁸⁴ J Harris and S Grace, *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s*, Home Office Research Study 196 (HMSO: London 1999).

⁸⁵ Ibid 23.

physical disabilities.⁸⁶ In 2005, Kelly et al. observed patterns of attrition in more than 2500 reported rape cases and found that the vast majority of these cases did not proceed beyond the investigative stage. Complainant withdrawal was identified as an important contributory factor to attrition as were ‘evidential issues’. These included the complainant’s learning difficulties, mental health issues or being unable to give a clear account.⁸⁷

In 2008, the CPS Policy Directorate research team reviewed 45 case files of ‘no prosecution’ and discontinued cases that involved complainants with recorded mental health problems and/or learning difficulties. Its objective was to provide insight into CPS prosecutorial decision-making in relation to complainants with mental health issues. However, the sample size was small and included only 25 cases where the file suggested the complainant had a mental health issue.⁸⁸

The study concluded that there was scope for improvement in the information gathered for these types of cases, but acknowledged difficulties accessing information regarding the complainant’s mental health. The research also highlighted the crucial role of the police in providing information sufficient for prosecutors to make informed decisions regarding continued prosecutions. A number of recommendations were made as a result, including the need for prosecutors to seek specific information on the impact of an individual’s mental health condition on

⁸⁶ S Lea et al, *Attrition of Rape Cases: Developing a Profile and Identifying Relevant Factors* (2003) 43(3) *Brit J Criminol* 583, 594. Although figures were not given.

⁸⁷ L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

⁸⁸ V Lee and C Charles, *Research into CPS decision-making in cases Involving victims and key witnesses with mental Health problems and/or learning disabilities* (CPS 2008).

cognitive abilities and the development of training materials to increase understanding amongst prosecutors.⁸⁹

Hester conducted the most recent study in 2013, examining attrition in a sample of 87 rape cases reported across three police force areas in the North-East of England.⁹⁰ According to these police records, nearly one in five victims had a mental health issue (19.5%).⁹¹ Hester's research found that cases involving vulnerable victims, which included those with extensive mental health problems, were least likely to progress through the criminal justice system or to be recorded as a crime in the first place.⁹² It was found that mental health issues were a significant feature in those cases that did not result in conviction.⁹³ Though one in five victims had a mental health issue, only around a third (35.2%) of cases where the victim presented mental health issues resulted in arrest. In cases where no such issues were recorded, 54.9% resulted in an arrest.⁹⁴

Such findings support previous discussion of cases involving complainants with mental health problems: cases in which the complainant has mental health issues rarely result, or are less likely to result, in the prosecution of the offender.⁹⁵ In accounting for this high attrition rate, Hester notes that police officers indicated that some of the victims with mental health issues were 'difficult to understand,

⁸⁹ Examples of current CPS training measures in regards to rape is set out in the CPS, *Violence against Women and Girls 2015-16: Crime Report* (2016) 56-57.

⁹⁰ M Hester, *From Report to Court: Rape Cases and the criminal justice system in the North East* (July 2013 University of Bristol and Northern Rock Foundation) 12-13.

⁹¹ However, in the majority of cases these were historical cases with rapes and sexual abuse taking place when the victims were children.

⁹² The study involved rapes reported to the police during May to November 2010, in 3 police force areas in the North East of England. The sample size was 87.

⁹³ M Hester, *From Report to Court: Rape Cases and the criminal justice system in the North East* (July 2013 University of Bristol and Northern Rock Foundation) 12-13.

⁹⁴ *Ibid.*

⁹⁵ J Harris and S Grace, *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s* (London Home Office 1999), S Lea, U Lanvers, and S Shaw, 'Attrition and Rape Cases: Developing a Profile and Identifying Relevant Factors' (2003) 43 *British Journal of Criminology* 583, L Kelly, Jo Lovett and L Regan, *A Gap or a Chasm? Attrition in reported rape cases* (Home Office Research Study 293 2005).

confused, or in their assessment delusional'. In such instances, the police typically regarded complainant stories as inconsistent and took the decision not to proceed further with the complaint.⁹⁶ These problems represent a key motive for focusing some/much of the discussion on the problems surrounding police identification of a mental health issue in Chapter 3.

Stanko and Williams' studies provide perhaps the most detailed attention to cases involving complainants with a background of mental health issues. Their 2009 research provides an analysis of 677 rape allegations recorded by the Metropolitan Police Service Crime Report Information Service (CRIS) during April-May 2005.⁹⁷ Of these allegations, one in three was recorded as 'no crime' (of which 30% were designated false allegations), 75% did not proceed beyond the police investigative stage and approximately 6% resulted in a conviction. The authors reported that 87% of complainants possessed at least one of four of the so called 'social believability vulnerabilities'. These complainant vulnerabilities included:

- being under 18 years of age;
- being under the influence of alcohol or drugs at the time of the rape;
- known to have 'mental health' issues and
- a former partner of the accused/perpetrator.⁹⁸

⁹⁶ M Hester, *From Report to Court: Rape cases and the Criminal Justice System in the North East* (University of Bristol in Association with the Northern Rock Foundation 2013).

⁹⁷ B Stanko and E Williams, 'Reviewing Rape and Rape Allegations in London: What are the Vulnerabilities of the Victims who Report to the Police?' in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009).

⁹⁸ The Havens publish yearly data which shows how complainants present in terms of vulnerabilities and these characteristics include alcohol, drug use, learning difficulties, disability or requiring an interpreter or mental health needs. During 2012/2014, 803 clients who attended the Havens presented with a total of 1201 vulnerabilities. 35% of the total vulnerabilities (422 times) related to alcohol being involved when the offence took place. The second highest vulnerability (25%) was the client suffering mental health needs (295 times). Cited in E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [347].

Of these ‘social believability vulnerabilities,’ mental ill-health was found *most likely* to have had an adverse impact on case outcome. Significantly, victims with mental health issues in this sample were three times less likely to have their allegations of rape classified as a crime and had reduced odds of reaching a conviction.⁹⁹ Again, the findings from this study are consistent with previous research regarding attrition.¹⁰⁰

Stanko et al. conducted a further study on attrition of rape reporting in England and Wales which provides an up-to-date picture of attrition patterns.¹⁰¹ This research was based on a sample of rape allegations reported to the Metropolitan Police Service in London during April and May 2012 and analysed 587 cases of female rape. The research focused on two main attrition pathways. Firstly, the complainant’s decision to withdraw the allegation: the research found that complainant withdrawal was responsible for failure to proceed in almost half of these cases. Complainant withdrawals were most likely to occur early in the process, with this likelihood declining as the case was referred to the CPS for charge. Secondly, the decision by police or the CPS to discontinue the case:¹⁰² 7% of allegations were recorded ‘no crime’, 40% ended with a police decision to take no further action, the remaining 30% of allegations dropped out due to a CPS decision to take no further action. The remaining 15% of non-withdrawn cases were awaiting trial.

⁹⁹ B Stanko and E Williams, ‘Reviewing Rape and Rape Allegations in London: What are the Vulnerabilities of the Victims who Report to the Police?’ in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009) 215.

¹⁰⁰ L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005); Feist A et al., *Investigating and Detecting Recorded Offences of Rape* (Home Office Online Report 18/07, 2007).

¹⁰¹ K Hohl and E Stanko, ‘Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales’ (2015) 12(3) *European Journal of Criminology* 324.

¹⁰² E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) [72].

This research also found that as far as police decision-making was concerned, “voluntary alcohol consumption prior to the rape, a history of consensual sex with the perpetrator, mental health problems and learning difficulties, and a woman’s ‘misunderstanding’ of the meaning of consent explained police decisions to discontinue a case.”¹⁰³ Investigator and prosecutor perceptions of credibility were found to be extremely influential. Only 2% of complaints in which police officers noted doubt about the allegation resulted in a CPS charge.

CPS staff involved in compiling a 2013 report on false allegations of rape¹⁰⁴ noted a striking similarity between the cases (in which the police decided to take no further action) referred to in their report and those examined by the national Rape Scrutiny Panel in 2014. Both sets of cases shared a similar pattern of complainant vulnerabilities including: mental health issues, learning disability/difficulties, repeat victimisation, and attention- and/or affection- seeking.¹⁰⁵ This supports a conclusion that investigator and prosecutor perceptions of complainant credibility are significant in decision-making and are influential in whether the rape allegation progresses. These studies also illustrate how a complainant vulnerability such as mental health can make a complaint less likely to be recorded as a crime or to progress.

The above findings are concerning given that research indicates that women in these groups can be target for sexual assault because of these vulnerabilities.¹⁰⁶

¹⁰³ Ibid [73], [74].

¹⁰⁴ CPS, *Charging Perverting the Course of Justice and Wasting Police Time in Cases Involving Allegedly False Rape and Domestic Violence Allegations: Joint report to the Director of Public Prosecutions* (2013) Alison Levitt QC and the Crown Prosecution Service Equality and Diversity Unit.

www.cps.gov.uk/publications/research/perverting_course_of_justice_march_2013.pdf.

¹⁰⁵ Ibid.

¹⁰⁶ N Burrowes, ‘Responding to the Challenges of Rape Myths in Court’ (NB Research: London 2013) <http://nb-research.co.uk/wp-content/uploads/2013/04/Responding-to-the-challenge-of-rape-myths-in-court_Nina-Burrowes.pdf> [accessed July 2016], S Oram, H Khalifeh and L Howard, ‘Violence against women and mental health’ (2017) 4(2) *The Lancet* 159.

Chapter summaries and thesis outline

This thesis examines specific procedural stages and decisions in the life of a rape allegation. These key stages are set out in Figure 1.2 below. The research considers decisions regarding progression or discontinuance that are made at a particular procedural point and how such decisions are connected with, and may be influenced by, issues of mental health in complainants. The key procedural points in the investigation and prosecution of a rape complaint examined here include: the initial reporting of the rape to the police, the complainant's interview with police (the Achieving Best Evidence Interview), the process of pre-trial disclosure and the use of counselling records or therapy notes as part of cross-examination of the complainant at trial.

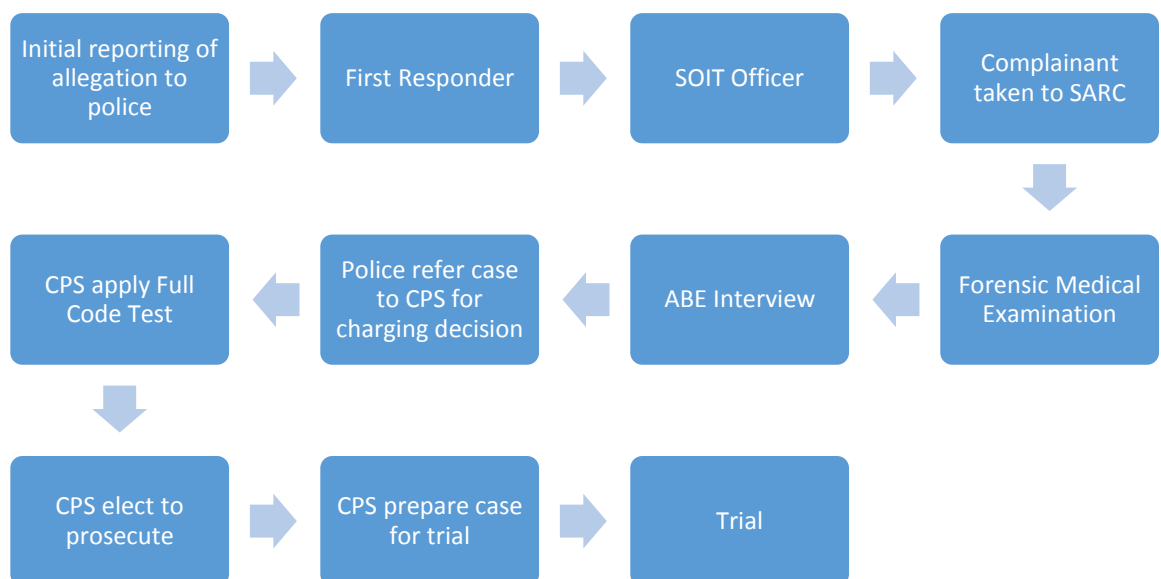


Figure 1.2: Key Stages in the Investigation and Prosecution of Rape Allegation

Chapter 2 underpins the whole thesis since it examines what constitutes a mental health condition and explains why mental health should be considered in the context of the criminal justice process. It sets out the system of classification of mental disorders and the corresponding hierarchy. The chapter addresses the stigma attached to mental health in society and considers how this stigma operates within the criminal justice process. The chapter examines, in close detail, bipolar disorder and this condition is used as an example of mental health conditions more broadly. Following an examination of the symptoms of bipolar, the chapter draws an obvious, but crucial link; it is clear that these symptoms are relevant and will have important ramifications in the context of the investigation and prosecution of a rape allegation. In this way, the thesis provides an important analysis of exactly how that can play out at each stage of the investigation and prosecution and thereby contributing to research in the area of mental health and rape.

The chapter also comments on the historical premise of the relevance of mental health evidence to a complainant's credibility in that if a rape allegation stems from the mind of a woman, the truth of the allegation requires complete investigation. It examines the link between mental health and women and how this connection has formed the basis for modern misconceptions about allegations of rape made by women with mental health issues.

Chapter 3 builds upon the arguments in Chapter 2 on the general context of reporting rape allegations and the fact that there are a number of barriers in regards to reporting the allegation such as a fear of not being believed by the police and a fear of the trial process. It was suggested that the barriers are further compounded for complainants with mental health issues, due to, as shown by evidence, the lack of

awareness surrounding mental health issues.¹⁰⁷ This can relate to an inability to recognise that a complainant has a mental health issue.

The chapter considers police treatment of the rape complainant at the initial reporting of the allegation. It considers how the initial reporting and early investigation of the allegation presents challenges for both the complainant and the police. These challenges pertain to two areas, firstly, for the complaint in terms of informing the police that she has a mental health issue. Secondly, for the police in terms of identifying that the complainant has a mental health issue. The unwelcome consequence of these challenges is that the complainant may not receive appropriate treatment that takes into account their condition. This can in turn lead to the complainant disengaging from the process and withdrawing the allegation, thereby increasing attrition rates. The early investigative stage is critical in light of the fact that complainant withdrawal occurs most frequently at the early stages of investigation. The first part of the chapter examines the current procedures, which are in place for the investigative phase, and considers the risks associated with complainants with mental health issues and the connection with attrition. Whilst guidelines are in place for police to follow and training has been implemented, the effects of policy implementation are slow to realise. This issue is especially important, since the scale of rape victimisation amongst complainants with mental health issues is significant and there are already weighty obstacles to formal disclosure of offences as well as difficulties that the police face in correctly identifying complainants with mental health issues. However, the second part of the

¹⁰⁷ M Horvarth and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009); L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005); J Temkin and B Krahé, *Sexual Assault and the Justice Gap: A Question of Attitude* (Hart Publishing 2008).

chapter will consider some positive initiatives, which demonstrate good practice in improving the complainant's experience in this area.

Chapter 4 examines the complainant's interview with the police and its impact on case progression and consequent relationship with rates of attrition. This interview, known as an 'Achieving Best Evidence' interview is a crucial piece of evidence and can be highly influential at trial. The chapter examines trauma and Post-Traumatic Stress Disorder and how characteristics of these mental health issues can affect both the quality of the complainant's account given during interview and how she appears to the interviewer. Both matters directly relate to the decision about whether the case will progress. The chapter considers the factors that lead to and justify non-progression decisions, and the role that mental health plays within such decisions.

Chapter 5 focuses on procedure, specifically pre-trial disclosure. In this instance, the allegation has been referred to the Crown Prosecution Service (CPS) for charge and the CPS have elected to prosecute. It is concerned with the process whereby the prosecution give information about the complainant's mental health to the defence. The range of material subject to disclosure rules is very broad, including medical records or counselling records after the offence occurred. The chapter focuses on the process of pre-trial disclosure and examines problems with the process itself (as distinct from when the material is adduced at trial). It sets the foundation for the next chapter, which examines the perceived relevance of material relating to the complainant's mental health and the consequence of its deployment at trial.

Chapter 5 details how the prosecution is under an obligation to disclose to the defence any material which may undermine its case or assist that of the defence. Different tests apply regarding material in possession of the prosecution and material

in possession of third parties. However, there is research to indicate that prosecutors do not always properly consider whether or not there is a need to disclose medical records and counselling notes pertaining to the complainant in their entirety. Furthermore, prosecutors did not appear to consistently consider whether or not a complainant's consent has been obtained regarding disclosure to the defence.¹⁰⁸ This is problematic in relation to possible breaches of a complainant's right to privacy. However, if the CPS do seek permission from the complainant to provide her medical records or counselling notes to the defence, a refusal to do so may mean that the case is discontinued. Although, in these circumstances, a complainant may make a Public Interest Immunity (PII) application to resist disclosure, it seems that, when deciding on the application, courts have generally found that the right to privacy outweighs the rights of the accused, particularly where relevance is unlikely. This chapter focuses specifically on the procedural aspects of disclosure, prosecutorial practices, and the outcome where the complainant refuses defence or prosecution access to certain materials, particularly the ones that relate to her mental health. This chapter explores how this relates to decisions to discontinue the case taken by the CPS.

The final attrition point in the criminal justice process is an acquittal, and Chapter 6, focuses on the trial process including the admission of material relating to the complainant's mental health at trial and its relevance and potential bearing on the outcome of a case. The relationship between disclosure procedure and the area of mental health is a complex one and gives rise to two further questions: firstly, what

¹⁰⁸ HMCPSI, *Disclosure of medical records and counselling notes : a review of CPS compliance with rules and guidance in relation to disclosure of complainant's medical records and counselling notes in rape and sexual offence cases* (July 2013) http://www.justiceinspectorates.gov.uk/crown-prosecution-service/wp-content/uploads/sites/3/2014/04/DOMRACN_thm_Jul13_rpt.pdf [accessed July 2016].

is the substance of the material? Secondly, why is this material being sought? The sixth and final substantive chapter addresses these questions and examines how there are substantial problems created by seeking to use this type of material at trial. It considers the issues surrounding admission of the complainant's personal information to the court and how such material can be used to unfairly discredit the complainant

Conclusion

What emerges from the research presented above is a troubling picture of the intersection of mental health issues and rape victimisation, especially when those victims are women. Despite some recent policy focus relating to the protection and involvement of victims in the criminal justice process, individuals with mental health issues appear to have been left behind by reform. These individuals are at higher risk of victimisation from all crime, and in particular from crimes of a sexual nature, including rape. In addition, the existence of mental health issues makes these victims less likely to report the crimes in question, a fact which is again compounded in cases of sexual violence and rape, and again especially for female complainants. Finally, even in cases that are reported, the criminal justice process places significant hurdles on the path of rape complainants with mental health issues, increasing an already high attrition rate.

Rape allegations involving complainants with recorded mental health issues are significantly more likely to suffer from attrition.¹⁰⁹ Women with a mental health issue are known to be at higher risk of criminal, sexual victimisation, yet only a small proportion of such cases progress through the investigative and prosecution

¹⁰⁹ L Ellison et al., 'Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation' (2015) 15(2) *Criminology & Criminal Justice* 225, 236.

process.¹¹⁰ For all these reasons, it is important to examine the way mental health issues affect the criminal justice process for female rape complainants. The initial step to this is to examine and analyse the concept of mental health, undertaken in Chapter 2.

¹¹⁰ D Sabsey and T Doe, 'Patterns of Sexual Abuse and Assault' (1991) 9 *Sexuality and Disability* 243, D Tharinger, C Horton and S Millea, 'Sexual abuse and exploitation of children and adults with mental retardation and other handicaps' (1990) 14 *Child Abuse and Neglect* 301.

CHAPTER 2: Bipolar Disorder: An Illustrative Examination of Symptoms and their Implication within the Criminal Justice Process

Introduction

The aim of this chapter is to look at what constitutes a mental health condition and to provide an example of how it might be relevant in the context of the judicial process. This explanation is given by way of background; it benefits the reader to understand, at a general level, the nature of a mental health condition and its symptoms in order to comprehend the potential ramifications when they come into play within criminal judicial proceedings, in particular in relation to issues of credibility and evidential quality.

The chapter begins by looking at the general stigma associated with mental health. It is important to note that the stigma is pervasive at the societal level, i.e. it exists well and truly beyond the legal system.¹¹¹ In light of the general societal stigma, and the fact that the evidence of a mental health condition is by legislation deemed relevant¹¹², it is pertinent to examine closely what happens when a mental health condition intersects with the criminal justice process, including whether and how the stigma continues to operate and other effects the condition may have on the outcome of the process.

¹¹¹ P Corrigan and A Watson, 'Understanding the impact of stigma on people with mental illness' (2002) 1(1) *World Psychiatry* 16-20, A Rogers and D Pilgrim, *A sociology of mental health and illness* (3rd edn, Open UP 2005), G Thornicroft, *Shunned: Discrimination against people with mental illness* (OUP 2006), O F Wahl, *Media Madness: Public images of mental illness* (Rutgers University Press 1995).

¹¹² Mental Health Act 1983, Mental Health Act 2007, and Mental Capacity Act 2005.

The chapter will briefly describe the hierarchy of mental disorders as prescribed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) and then examine in depth the cause, prevalence and symptoms of one mental health condition: bipolar disorder.¹¹³ Bipolar disorder is used as an example of mental health conditions more broadly because it is illustrative of the important elements of a mental health condition. Symptoms will be discussed whose ramifications and effects for and on the investigative and prosecutorial process can be tangibly charted. The reason for this analysis of bipolar disorder is to demonstrate the risk associated with each symptom to the rate of attrition.

It is also worthwhile examining mental health and women in particular, given the material that shows that historically women's mental health was thought to be relevant to allegations of sexual offending, feeding into misconceptions around false allegations of rape and sexual offences more generally. This thesis finds that such misconceptions have a continuing effect on the adjudication of sexual offences.

The chapter will conclude that when looking at the symptoms common to many mental health disorders and comparing them to relevant considerations in a judicial process, e.g. credibility and the complainant's ability to withstand the criminal justice process, it is clear that the mental health condition is likely to have an effect, and that exploration of those effects is warranted. This will follow in subsequent chapters.

The Stigma of mental health in society

What are some of the historical ideas relating to mental health and what can we learn about the origins of mental health stigma? Firstly, Byrne notes that the West has

¹¹³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (5th edn, American Psychiatric Publishing 2013).

always linked ideas of morality and virtue with health and reason.¹¹⁴ If an individual is sane, he/she is healthy and ‘good’. This is reflected in the modern expression ‘mental illness’, the word ‘illness’ suggesting the person is in some way unwell or there is something ‘wrong’ with them. Early Christian societies associated ‘madness’ with ‘images of the demonic, the perverse, the promiscuous and the sinful.’¹¹⁵

Moreover, there are many misconceptions and misunderstandings surrounding mental health. Having a mental health condition or mental health issues can be stigmatising.¹¹⁶ *The Oxford Dictionary* defines stigma as a ‘mark of disgrace’ and the term is associated with a particular circumstances, quality or person.¹¹⁷ Stigma occurs in a complex mix of relationships involving labelling, stereotyping, discrimination and power imbalances.¹¹⁸ As Smith notes, in a sense, stigma is not really a ‘mark’; rather it is a ‘dynamic and relational process’.¹¹⁹ It is composed of three elements – ignorance, prejudice and discrimination. Ignorance relates to problems of knowledge, prejudice concerns negative attitudes and discrimination relates to behaviour.¹²⁰ All are particularly concerning when imagined within a legal process. Many studies have shown that stigmatising attitudes towards people with mental health issues are widespread and commonly held.¹²¹ Hayward and Bright

¹¹⁴ P Byrne, ‘Psychiatric Stigma’ (2001) 178 *British Journal of Psychiatry* 281.

¹¹⁵ A Schlosberg, ‘Psychiatric Stigma and Mental Health Professionals Stigmatisers and Destigmatisers’ (1993) 12(3-5) *Medicine and Law* 409, 410.

¹¹⁶ B Link and J Phelan, ‘Conceptualising Stigma’ (2001) 27 *Annual Review of Sociology* 363; J G Rabkin, ‘Public attitudes toward mental illness: a review of the literature (1974) 10 *Schizophrenia Bulletin* 9-33; P Hayward and J Bright, ‘Stigma and Mental Illness: A Review and Critique’ (1997) 6 *Journal of Mental Health* 345; G Thornicroft, *Shunned: Discrimination against people with mental illness* (OUP 2006).

¹¹⁷ Oxford Dictionary, ‘stigma’, <https://en.oxforddictionaries.com/definition/stigma> [accessed Jan 2017].

¹¹⁸ B G Link, JC Phelan, Conceptualizing Stigma (2001) 27 *Ann Rev Sociology* 363.

¹¹⁹ M Smith, ‘Anti-stigma campaigns: time to change’ (2013) 202 *The British Journal of Psychiatry* s49-50.

¹²⁰ G Thornicroft, Diana Rose, Aliya Kassam, Norman Sartorius, ‘Stigma: ignorance, prejudice or discrimination?’ (2007) 190(3) *The British Journal of Psychiatry* 192-193.

¹²¹ P Byrne, ‘Psychiatric stigma: past, passing and to come’ (1997) 90 *Journal of the Royal Society of Medicine* 618; B G Link et al., ‘On stigma and its consequences: evidence from a longitudinal study of men with dual diagnoses of mental illness and substance abuse’ (1997) 38 *Journal of Health and*

conducted a review of the literature on stigmatisation of persons with mental health issues, concluding that there was an ongoing perception that people with mental health issues were ‘dangerous’, ‘unpredictable’, ‘being difficult to talk with’ and ‘having themselves only to blame.’¹²² The consequence is that individuals with mental health issues feel devalued, ignored and isolated.¹²³ They experience shame, ostracism, and marginalisation due to their diagnosis, describing the consequences of mental health stigma as worse than those of the condition itself.¹²⁴ Discrimination can compound the barriers related to the primary symptoms of mental health conditions, and lead to disadvantages in many aspects of life, including personal relationships, education, and employment.¹²⁵ It can also limit opportunities through loss of income, unemployment, reduced access to housing or health care.¹²⁶

The proposition that having a mental health condition prevents an individual engaging in life is reflected in MIND’s 2011 survey of 2,770 people. The research found that 80% of respondents had experienced stigma and discrimination because of their mental health problems. Stigma Shout, a 2008 survey of 3699 people, found

Social Behaviour 177, A F Jorm et al., ‘Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals’ (1999) 33 *Australian and New Zealand Journal of Psychiatry* 77-83, J G Rabkin, ‘Public attitudes toward mental illness: a review of the literature’ (1974) 10 *Schizophrenia Bulletin* 9-33; C Heginbotham, ‘UK mental health policy can alter the stigma of mental illness’ (1998) 352 *Lancet* 1052; R Porter, ‘Can the stigma of mental illness be changed?’ (1998) 352 *Lancet* 1049.

¹²² P Hayward and J A Bright, ‘Stigma and Mental Illness: A Review and Critique’ (1997) 6 *Journal of Mental Health* 345.

¹²³ A Crisp, M Gelder, S Rix, H Meltzer, O Rowlands, ‘Stigmatisation of people with mental illnesses’ (2000) 177 *British Journal of Psychiatry* 4.

¹²⁴ G Thornicroft et al., ‘The health crisis of mental health stigma’ (2016) 387 *The Lancet* 1027 (editorial). Furthermore, stigma becomes even more problematic for individuals with multiple, complex needs, already pushed to the margins of their communities; society is particularly cruel to those with personality disorders, homelessness, addiction, or criminal convictions.

¹²⁵ M Slade, *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals* (CUP 2009) 29, G Thornicroft, *Shunned: Discrimination against people with mental illness* (OUP 2006).

¹²⁶ L Yang S H Cho, A Kleinman, ‘Stigma of Mental Illness’, in V Patel (ed) *Mental and neurological public health: a global perspective* (Elsevier 2010).

that 87% of participants reported that they had experienced stigma.¹²⁷ These findings are consistent with other research.¹²⁸ Although education and public awareness campaigns are doing much to improve the situation, there is still more to do in changing public perception and encouraging positive attitudes towards mental health.¹²⁹ These matters will be relevant to whether the complainant informs the police of a rape allegation, if she discloses the fact of having a mental health condition, and to how the complainant is perceived in terms of credibility during the police interview etc. These issues are considered in more detail in the subsequent chapters.

Having looked at the stigma generally associated with mental health conditions, it is now necessary to analyse precisely what is meant by ‘mental health condition’ (in a legal context).

What is a mental health condition?

This thesis considers what happens when a mental health condition intersects with the criminal justice process. More specifically, it considers the relevance and impact of such a condition on the investigation and prosecution of a rape allegation and whether it influences decisions the police and CPS make about a case. It is therefore

¹²⁷ Time to Change, Rethink and Mind, ‘Stigma Shout: Service user and carer experiences of stigma and discrimination’ (2008) www.time-to-change.org.uk/sites/default/files/Stigma%20Shout.pdf [accessed Nov 2016]

¹²⁸ S Farrelly et al., ‘Anticipated and Experienced Discrimination amongst People with Schizophrenia, Bipolar Disorder and Major Depressive Disorder: A Cross Sectional Study’ (2014) 14(1) BMC Psychiatry 157.

¹²⁹ G Thornicroft et al., ‘Evidence for effective interventions to reduce mental-health-related stigma and discrimination’ (2016) 387 The Lancet 1123. In the UK for example, Mind and Rethink Mental Illness’s ‘Time to Change’ is a campaign which has been running since 2007 whose objective it is to reduce the stigma and discrimination associated with mental health. A similar campaign, ‘Black Dog’, is run by the charity SANE. Elsewhere, in 1996, the World Psychiatric Association launched its ‘Open the Doors’ campaign against the stigma of schizophrenia. Large-scale public campaigns followed in several countries: New Zealand (‘Like Minds, Like Mine’, 1997), Scotland (‘see me’, 2002); the USA (‘What a Difference a Friend Makes’, 2006) and Canada (‘Opening Minds’, 2009).

important to deepen our understanding of what is meant by a ‘mental health condition’.

The various definitions of mental health were provided in Chapter 1 and reference was made to the fact that courts in England and Wales follow the definition in the MHA 1983. The statute provides that ‘mental disorder’ means any disorder or disability of the mind.¹³⁰ The American Psychiatric Association gives a more detailed definition:

A mental disorder is a syndrome characterised by clinically significant disturbance in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.¹³¹

In a broad sense, seeking counselling or speaking to a therapist also forms part of the notion of mental health. However, ‘mental health’ can also encompass a recognised medical condition. The following part outlines the way in which mental health conditions are classified, the systems of classification and the hierarchy of mental health conditions. This is in order to provide context for the reader and to provide authority for how these conditions are referred throughout the thesis.

Classification of mental disorders

In psychiatry, there are two main ways to classify mental health conditions. First is the ideographic approach, where each patient is analysed individually, an approach which avoids classifying unusual behaviour into diagnostic groups. The second method is the nomothetic approach, which classifies and categorises disorders. The nomothetic approach, known as ‘descriptive psychopathology’, is the prevailing

¹³⁰ Section 1(2) MHA 1983.

¹³¹ American Psychiatric Association, DSM-V (5th edn, American Psychiatric Publishing 2013) 20.

one.¹³² Globally, in the area of mental health, two main classification systems are used: the Diagnostic and Statistical Manual of Mental Disorders (DSM-V)¹³³ and the International Classification of Diseases (ICD-10).¹³⁴ Both are broadly similar and categorical in their approach to mental health conditions. The ICD-10 is the World Health Organisation's diagnostic manual that lists all recognised diseases and disorders, including the category 'mental and behavioural disorders'. In the UK, mental health professionals refer to an ICD-10 diagnosis. The DSM-V is used in the US and worldwide. This thesis focuses predominantly on conditions as described in the DSM-V Manual because of resource access issues. However, 'both systems share the overarching goal of harmonising the two classifications as much as possible'.¹³⁵ These sets of classifications are intended to provide worldwide standards and criteria for the recognition of mental health issues for persons in clinical practice and for researchers.¹³⁶ The classification systems are based on groups rather than individuals and set out a general framework to understand mental health conditions.

The idea of using classification systems and diagnostic labels to describe the highly complex vagaries of the human mind often meets with fierce resistance in mental health circles.¹³⁷ The 'medical model' of psychiatry – diagnosis, prognosis and treatment – is essentially a means of applying the same scientific principles to the study and treatment of the mind as physical medicine applies to diseases of the body. In psychiatry, symptoms often overlap with one another – various diagnostic terms are commonplace in health and social care and have some descriptive power –

¹³² T Bajorek and T Stockman, *Psychiatry* (JP Medical Ltd 2012) 21.

¹³³ The Diagnostic and Statistical Manual of Mental Disorders. This is currently in its 5th revision and is published by the American Psychiatric Association.

¹³⁴ International Classification of Diseases – 10th Revision. This is produced by the World Health Organisation.

¹³⁵ American Psychiatric Association, *DSM-V* (5th edn, American Psychiatric Publishing 2013) 11.

¹³⁶ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 40.

¹³⁷ *Ibid* 19.

although it is important to remember that individuals may experience a complex array of feelings, experiences or ‘symptoms’ that may vary wildly with the individual over time and from situation to situation.¹³⁸ One criticism of psychiatric classification systems is that they pigeonhole individuals and apply diagnostic labels to them. ‘...[m]any patients have more than one psychiatric disorder. It is well established that having one psychiatric disorder increases the risk of having another and that over 50% of psychiatric patients have two or more diagnoses.’¹³⁹

Moreover, there is a range of mental health conditions; each condition is different and every individual will have a different experience of a specific condition. Consequently, one cannot make general statements of application. ‘Patients sharing the same diagnostic label do not necessarily have disturbances that share the same aetiology (i.e. the cause, set of causes or manner of causation of a disease or condition) nor would they necessarily respond to the same treatment.’¹⁴⁰ Furthermore, what constitutes a mental health issue can also be a matter of degree. That is, an individual may have a diagnosed condition but his/her experience of it will vary according to that person’s specific circumstances. This is further mediated by the strength of the condition. For example, depression operates on a continuum ranging from mild depression to severe, rather than an ‘all or none’ view. Lastly, there are a range of factors influencing an individual and his/her experience of a mental health condition: biological, environmental, social cognitive and psychological. This highlights how mental health is a highly individualised and variable concept.

¹³⁸ Ibid 41.

¹³⁹ T Bajorek and T Stockman, *Psychiatry* (JP Medical Ltd 2012) 23.

¹⁴⁰ DSM-IV-TR (www.dsmivtr.org).

Hierarchy of mental disorders

Both the DSM-IV and the ICD-10 systems refer to and employ a diagnostic hierarchy of mental disorders; this is illustrated in figure 2 below. At the top of the hierarchy are organic conditions such as delirium or dementia. This is followed by psychotic or delusional disorders such as schizophrenia, then affective or mood disorders such as bipolar, depression, followed by anxiety and stress related disorders. Finally, the hierarchy closes with disorders relating to personality and behaviour.

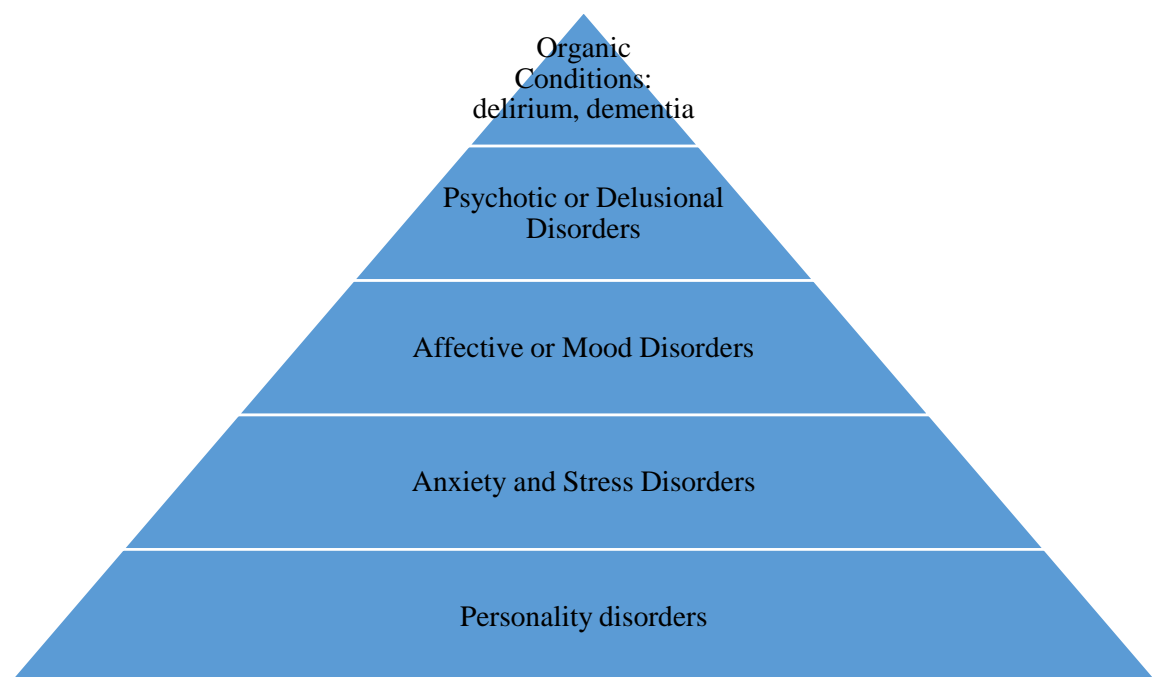


Figure 2: Hierarchy of Mental Disorders¹⁴¹

The literature in this area, e.g. CPS and police guidelines and government publications, tends to speak only generally of ‘mental health’. Therefore, one useful way to approach the research question is to consider specific symptoms whose

¹⁴¹ Adapted from ‘The diagnostic hierarchy of psychiatric disorders’ in T Bajorek and T Stockmann, *Psychiatry* (JP Medical Publishers 2012) 23.

significance and effects for and on the criminal justice process can be more precisely tracked. In order to clearly demonstrate the point the symptoms of a mental health condition have the potential to influence investigative and prosecutorial process, the symptoms of just one mental health disorder will be considered. Bipolar disorder is illustrative generally of the important elements of a mental health condition, in that it contains symptoms, which are common to many mental health conditions. Furthermore, like many mental health conditions, bipolar exists on a spectrum, there are a variety of causes and symptoms of differing severity and duration.

The ways in which a complainant experiences the symptoms of a mental health condition are particularly important. This is because this is something that affects both the complainant's ability to deliver an account of the allegation and the way that account is received and assessed, meaning how others perceive both the complainant herself and the account she gives to the police, prosecutors and jurors. For example, the symptoms of depression may mean that the complainant is seen as confused or mistaken about past events, or the symptoms of schizophrenia render the complainant seemingly untrustworthy. Such symptoms can therefore directly influence the decision to progress or discontinue a case.

The prevalence, causes and symptoms of bipolar disorder will now be considered in the context of their general potential impact on the complainant and her allegation in the judicial process.

Affective or mood disorders: Bipolar disorder

Bipolar, *adj.*

Having two poles, as in a bipolar cell or bipolar neuron; or more generally having two extremes or extremities, as in a bipolar adjective pair such as *good–bad*, frequently used in rating scales.¹⁴²

Bipolar disorder is a mood disorder where the sufferer experiences extreme mood disturbances with periods of severe highs (mania) and severe lows (depression) interspersed with periods of improvement and emotional stability and function.¹⁴³

The occurrence of manic or hyperactive episodes distinguishes bipolar disorder from depression.¹⁴⁴ Bipolar is ‘inherently complex and unpredictable, and diagnosis and treatment are both compounded by the context in which the disorder manifests’.¹⁴⁵

Approximately 1% of the population has bipolar; this mirrors the prevalence of schizophrenia.¹⁴⁶ Bipolar usually begins in late adolescence to early twenties, with men and women equally affected. It is usual for sufferers to experience years of symptoms before a diagnosis is made.¹⁴⁷

Causes and prevalence of bipolar disorder

Research suggests that there is no single cause of bipolar, rather that several factors operate together. Stressful life events, genetics, childhood development and brain biology all play an important role in the development of the condition.¹⁴⁸ It is thought that bipolar is biologically determined to a certain extent but a combination of ‘trigger factors’ increase the likelihood of developing the condition, especially for

¹⁴² A Colman, *A Dictionary of Psychology* (4th edn, OUP) (online).

¹⁴³ It was formerly known as manic depression. The condition is a bridge between schizophrenia and other psychotic disorders and depressive disorders. DSM-V, (5th edn, American Psychiatric Publishing 2013) 123.

¹⁴⁴ Bipolar involves both depression and an abnormally elevated mood whereas unipolar is the abnormally depressed mood only.

¹⁴⁵ G Malhi, ‘Bipolar disorder: key clinical considerations’ (2015) 387 *The Lancet* 1561.

¹⁴⁶ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 22.

¹⁴⁷ *Ibid* 23.

¹⁴⁸ I Jones, L Kent and N Craddock, ‘The genetics of affective disorders, in P McGuffin, I Gottesman and M Owen (eds), *Psychiatric Genetics and Genomics* (OUP 2002).

those who are psychologically and genetically vulnerable.¹⁴⁹ For example, studies by Garno et al., found that sufferers had histories or incidences of childhood trauma or abuse.¹⁵⁰ Mueser et al. reported that a lifetime prevalence of traumatic events amongst a sample of 275 patients with bipolar disorder and schizophrenia was 98%.¹⁵¹ The lifetime rate for trauma in the general population ranges between 39% and 56%.¹⁵² Challenging life situations act as triggers for episodes and such stressors may relate to the individual's social and economic class, level of social support and general self-esteem.¹⁵³ High expressed emotion also increases the risk of depressive episodes.¹⁵⁴ There are psychosocial influences also i.e. psychological and social factors with are associated with the condition. Other known causal factors these include sleep deprivation, drugs and other stimulants like antidepressants and alcohol or neurological causes including head injuries or epilepsy. Structural brain differences are a factor and frontal and temporal lobe abnormalities have been found in people with bipolar disorder.

Symptoms

There are two phases of the condition – a manic phase and a depressive phase. The manic phase usually has an acute onset and if left untreated can last up to six months.

The depressive phase last longer, around six months to one year. The frequency of

¹⁴⁹ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 26.

¹⁵⁰ J Garno et al., 'Impact of childhood abuse on the clinical course of bipolar disorder' (2005) *Br J Psychiatry* 121

¹⁵¹ K Mueser et al., 'Trauma and post-traumatic stress disorder in severe mental illness' (1998) 66 *J Consult Clin Psychol* 493–499.

¹⁵² R C Kessler et al., 'Post-traumatic stress disorder in the National Comorbidity Survey' (1995) 52 *Arch Gen Psychiatry* 1048–1060.

¹⁵³ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 53.

¹⁵⁴ High expressed emotion is the critical, hostile and emotionally over-involved attitude that relatives have toward a family member with a mental disorder. The stress from the negative criticism becomes a burden on the individual with the disorder and the only way to cope is relapse. L McDonagh, 'Expressed emotion as a precipitant of relapse in psychological disorders' (2004) 363 *The Lancet* 2063.

relapses into either phase increases with age.¹⁵⁵ Women have a higher lifetime risk of alcohol use disorder than males and a much greater likelihood of alcohol use disorder than do females in the general population.¹⁵⁶ Both the manic and depressive phases of bipolar are often triggered by pressure and anxiety or stressful life events such as a death or redundancy.¹⁵⁷

Throughout the course of the condition, the individual usually experiences lengthy periods of emotional and social stability. Their stability is usually interspersed with shorter episodes of low mood or extreme excitement. Rather than the mistaken popular view that the manic and depressive phases alternate neatly with one another, one mood is often experienced more frequently and more severely than the other.¹⁵⁸ Furthermore, the severity of the condition and duration of episodes varies from each person to the next. If the individual has support of family, medical professionals and mood stabilising medication, the condition tends not to have the same degree of social withdrawal as compared with other mental disorders, such as schizophrenia.¹⁵⁹

Individuals may suffer from a ‘rapid cycling’ form of bipolar. In this instance, extreme moods are experienced more than four times in one year. Individuals may experience psychotic symptoms and altered moods for much of their adult life, leading to significant lifestyle disruption. This form of bipolar is the most debilitating and disruptive. Severe symptoms and rapid cycling have been associated with cognitive impairment and a reduced ability to think, reason and solve problems

¹⁵⁵ T Bajorek and T Stockman, *Psychiatry* (JP Medical Ltd 2012) 84.

¹⁵⁶ American Psychiatric Association, *DSM-V* (5th edn, American Psychiatric Publishing 2013) 130.

¹⁵⁷ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers 2006) 24

¹⁵⁸ *Ibid* 22.

¹⁵⁹ *Ibid* 23.

as well as significant social disability including great difficulties in forming and maintaining relationships and finding employment.¹⁶⁰

Mania – the ‘high’ and associated risks within the criminal justice process (and beyond)

The manic phase or episode is a period of elation, over-activity and grandiose beliefs. Initially, the manic phase can appear simply as restlessness or insomnia. Those with a history of the condition may know that this is an early warning sign and seek treatment in order to avoid progressing to complete mania.¹⁶¹ As the mania progresses the person’s speech becomes louder, faster, and increasingly disorganised, jumping from one topic to another in no particular order. The individual is easily distracted – attention is too easily drawn to unimportant or irrelevant external stimuli.¹⁶² Ideas appear faster than the person can express them, leading to even more rapid and incomprehensible speech.¹⁶³

In the context of giving an account to the police during interview or whilst providing testimony at trial, if a rape complainant with bipolar was experiencing the manic phase of the condition such symptoms may affect how she delivers her testimony and appears to the jury. Her answers to questions may be confused and incomprehensible to the jury, thereby making her testimony less credible simply because it is difficult to follow. The complainant’s impaired concentration may affect her ability to provide a coherent and complete account of the allegation.

¹⁶⁰ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 23

¹⁶¹ B Adams, *The Pits and the Pendulum: A Life with Bipolar Disorder* (Jessica Kingsley Publishers 2002).

¹⁶² American Psychiatric Association, *DSM-V* (5th edn, American Psychiatric Publishing 2013) 124.

¹⁶³ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 25.

Other symptoms include an elevated, distracted and irritable mood.¹⁶⁴ Characteristically, as the manic episode progresses, the sufferer loses insight into their situation and the reality of their ideas. At this stage, delusional beliefs of superiority, wealth and a sense of inflated self-esteem begin to surface. However, if such symptoms were exhibited during the complainant's interview with police this may affect their assessment of her credibility and character. Although it is worth noting that character is not a legal consideration for the police. Increased self-esteem and a low threshold for irritability may not endear the complainant to the jury's sympathies.

During a manic episode, there is an increase in goal-orientated activity as the person feels a sense of extreme power, creativity and energy.¹⁶⁵ The individual participates in gratifying activities without consideration of the consequences, such as shopping sprees, business investments or sexual indiscretions. Behaviour can become increasingly bizarre, often involving uncharacteristically loud clothing or extreme restlessness (for example, running instead of walking). The manic phase is often described as one of elation. However, aggression or irritability are common, especially where the individual's ideas are contradicted or someone seeks to curtail their behaviour.¹⁶⁶ This symptom could be problematic during cross-examination of the complainant at trial. Here the complainant could appear combative and arrogant in response to counsel's questions. If the complainant is experiencing hypomania this may mean that she lacks an appreciation of the significance of questions and may also lead her to make 'exaggerated statements or false claims because of elation or ebullience'. The complainant may also underplay the seriousness of an

¹⁶⁴ American Psychiatric Association, DSM-V (5th edn, American Psychiatric Publishing 2013) 124.

¹⁶⁵ Ibid.

¹⁶⁶ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers 2006) 25.

allegation.¹⁶⁷ This has obvious consequences for how the complainant's account is elicited during her interview with the police, a topic considered in Chapter 4.

There is potential for serious repercussions for the complainant's ongoing mental and physical well-being during the manic stage, and, if left untreated it may result in physical injury. Additionally, with their reckless behaviour the individual risks harming their financial, employment or relationship status, for example if the individual spends thousands on shopping sprees.¹⁶⁸ There is a danger of being lured into a financial fraud or manipulation, or suffering financial difficulties due to the excessive spending. Consequently, if the individual is left untreated and without support, she becomes extremely vulnerable to exploitation.

Exploitation in the manic phase is not necessarily financial; individuals are also prone to sexual exploitation and are extremely vulnerable due to their disinhibition and reckless attitude. This is clearly relevant for complainants who are subject to sexual offending. Furthermore, sexual behaviour during the manic phase can include 'infidelity or indiscriminate sexual encounters with strangers', often disregarding the risk of sexually transmitted disease or interpersonal consequences.¹⁶⁹ This is a factor that may be used against the complainant at trial, in the form of previous sexual history evidence, if the behaviour were to satisfy the admissibility requirements of s41 of the Youth Justice and Criminal Evidence Act 1999 (YJCEA 1999).¹⁷⁰

¹⁶⁷ Advocates Gateway, 'General principles when questioning witnesses and defendants with mental disorder (Toolkit 12) (Advocacy Training Council July 2014) [3.17]. <http://www.theadvocatesgateway.org/images/toolkits/12-general-principles-when-questioning-witnesses-and-defendants-with-mental-disorders-2014.pdf> [accessed Feb 2016].

¹⁶⁸ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers 2006) 24.

¹⁶⁹ American Psychiatric Association, *DSM-V* (5th edn, American Psychiatric Publishing 2013) 129.

¹⁷⁰ However, this is a different and complex issue which is not explored in this thesis, but is worth noting.

Manic phases are carry a related risk of physical harm. Furthermore, decreased sleep can lead to accidental injuries and substance misuse, self-neglect and exhaustion are all possibilities. If there is no medical intervention or support, individuals may require hospital admission.

Depression - the ‘low’ and associated risks within the criminal justice process (and beyond)

The depressive phase often follows the manic phase. The suicide rate for bipolar is approximately 20% and the risk is highest during the depressive episodes, particularly those who are in early stages of the illness.¹⁷¹ The feelings of intense low mood, fatigue, inability to concentrate and lack of motivation associated with depression represent the total opposite of the manic phase.

The onset of depression in bipolar disorder tends to be sudden and dramatic.¹⁷² At its most serious, a depressive episode has the potential to leave an individual mute and immobile, unable to communicate or carry out even basic tasks such as washing, dressing or eating. How will a complainant in the depressive phase of bipolar present to the jury? The complainant may appear dishevelled, disinterested and therefore lacking in credibility. An inability to concentrate will affect the complainant’s response to questions put to her.

Episodes of severe depression, and its intense symptoms, can lead to a significant risk of self-neglect and suicide. At its most serious and incapacitating, depression can lead to an inability to move, communicate or carry out basic tasks such as eating

¹⁷¹ T Bajorek and T Stockman, *Psychiatry* (JP Medical Ltd 2012) 90, Chen Y W and Dilsaver S, ‘Lifetime rates of suicide attempts among subjects with bipolar and unipolar disorders relative to subjects with other axis I disorders’ (1996) 39(10) *Biological Psychiatry* 896.

¹⁷² C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 25.

or drinking.¹⁷³ In this instance, hospitalisation may be required to ensure the person's health and safety and to assist with nutrition, hydration and self-care. Anti-depressants may be required or even electroconvulsive therapy (ECT).¹⁷⁴ Even mild and moderate episodes of depression can still leave the individual unable to leave the house or get out of bed without considerable effort. Suicidal thoughts are not uncommon, and in such cases, medical assessment and intervention is required. Obviously, participation in the criminal justice process while suffering any of these conditions would present serious challenges to the complainant and her ability to coherently recollect and recount her complaint.

A depressed person often experiences intrusive negative thoughts, with constant rumination over past events, current problems or perceived future disasters. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) may influence how the complainant views the allegation and the circumstances of the offence i.e. attributing self-blame where this is misplaced. They may voice such negative beliefs such as 'what is the point of living?' and 'everyone hates me, including me'. They may not respond to reassurance from those around them.¹⁷⁵ Sufferers experience a general feeling of hopelessness and very low self-esteem.¹⁷⁶ This may impact upon the complainant's decision to report the allegation, in light of the belief that no outcome will help them.

Substance misuse and dependence have a close relationship with depression, with heavy drinkers and drug users being more likely to be clinically depressed than the

¹⁷³ Known as 'mental retardation.'

¹⁷⁴ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 29.

¹⁷⁵ *Ibid* 30

¹⁷⁶ *Ibid* 29-30.

general population.¹⁷⁷ Attempts to self-medicate with alcohol or drugs often lead to substance misuse.¹⁷⁸ Psychotic symptoms such as loss of insight, hallucinations and delusional ideas are likely to occur as part of bipolar disorder. The symptoms typically take the form of paranoia or derogatory voices, as opposed to the grandiose and bizarre ideas a person may express during the manic phase. At this stage, the risk of suicide increases, due to the severe depression. This is even greater where the person is troubled by voices or delusional ideas. This may involve ‘commands’ to the individual to self-harm or suicide.¹⁷⁹

All of these symptoms have potential ramifications for the complainant’s ability and willingness to engage in the investigation of the allegation. One reason for an ‘unsuccessful outcome’ as defined by the CPS is ‘victim issues’, which includes the victim withdrawing their support for the case.¹⁸⁰ However, this may actually be the result of the complainant being perceived as ‘uncooperative’ or unwilling to testify and difficult to work with. The complainant may have difficulty going to the police station to make a statement. This could have an effect on either the police or CPS decision to continue with the case.

What does the case study of bipolar tell us about the potential ramifications of a mental health condition on the investigation and prosecution of a rape allegation? The discussion highlights how the symptoms of bipolar can be influential as to how the complaint is perceived and progresses, or the ability of the complainant to

¹⁷⁷ T Weaver, A Renton and G Stimson, ‘Severe mental illness and substance misuse’ (1999) 319 *British Medical Journal* 137-138.

¹⁷⁸ K R Merikangas et al., ‘Specificity of bipolar spectrum conditions in the comorbidity of mood and substance use disorders: results from the Zurich cohort study’ (2008) 65 *Arch Gen Psychiatry* 47, R M Post and P Kalivas, ‘Bipolar disorder and substance misuse: pathological and therapeutic implications of their comorbidity and cross-sensitisation’ (2013) 202(3) *The British Journal of Psychiatry* 172.

¹⁷⁹ C Kinsella and C Kinsella, *Introducing Mental Health: A Practical Guide* (Jessica Kingsley Publishers, 2006) 26.

¹⁸⁰ CPS, VAWG Crime Report 2015-16 (September 2016) 49

http://www.cps.gov.uk/publications/docs/cps_vawg_report_2016.pdf [accessed Feb 2017].

continue with her allegation or indeed to report the allegation in the first place. Some of the symptoms between mental disorders overlap, for example delusions are psychosis are common to both bipolar and schizophrenia, and the symptoms of depression are common to both bipolar and unipolar depression. These associated symptoms could also be influential during the processing of an allegation. The above discussion illustrates how the symptoms of bipolar can be influential as to how a complaint is perceived and progresses, or the ability of the complainant to continue with her allegation or indeed to report the allegation in the first place. These matters all have a bearing on the rate of attrition.

Arguably the risks associated with mental health are heightened when the offences are sexual and the complainant is female.¹⁸¹ We also know of the stigma associated with having a mental health issue and later chapters of this thesis explore further stigma and assumptions made in the context of women's mental health and sexuality specifically. For this reason, as a closing point to the chapter, it is pertinent to dwell particularly on women and mental health because of the historical connection drawn between female mental health and fabrications of sexual allegations. This issue will now be discussed.

Part of the historical construction of rape law involves that the 'word of a woman' was seen as inherently unreliable.¹⁸² What is the reason for the association made between women's mental health and sexuality? Any answer to this question must begin with an examination of the historical origins of the link between mental health and rape complainants. By tracing the development of the link, this chapter will show how material relating to a woman's mental health was thought to be relevant to

¹⁸¹ See literature discussed in Chapter 1: 'The scale of victimisation of complainants with mental health issues.'

¹⁸² J Jordan, *The Word of a Woman: Police, Rape and Belief* (Palgrave 2004).

allegations of sexual offending and how such a (mis)conception continues to influence modern criminal investigations and prosecutions. The following chapters in the thesis focus then focus on a specific stage in the investigation or prosecutorial process where that continuing influence is seen, and the often detrimental effect that a complainant's mental health can have on the assessment of the complainant and her allegation.

Historical context: Freud and psychoanalysis

Associations between madness, sinful and promiscuous have always been gendered and characterise women's sexuality in particular as dangerous.¹⁸³ Many academics have noted the historical link made between rape complainants and mental disorders.¹⁸⁴ There is an underlying belief that some women falsely accuse men of rape because they are psychologically disturbed and/or unable to distinguish between rape and consensual intercourse.¹⁸⁵ The origins of this view form part of a historical tendency to doubt the testimony or credibility of women, especially when it comes to sexual matters. The view can be traced to the nineteenth century and the emergence of the idea of the 'Victorian madwoman'. During this period, the close association between women and madness became firmly established within scientific, literary

¹⁸³ J Benedet and I Grant, 'Sexual Assault and the Meaning of Power and Authority for Women with Mental Disabilities' (2014) 22(2) *Fem Leg Stud* 131, 139.

¹⁸⁴ See S Edwards, *Female Sexuality and the Law* (Martin Robertson 1981); M Heenan and H McKelvie, 'Evaluation of the Crimes (Rape) Act 1991' (Melbourne Department of Justice, 1997), B Brown, M Burman and L Jamieson, *Sex Crimes on Trial* (Edinburgh UP 1993); C Smart, *Feminism and the Power of Law* (Routledge 1989); A Taslitz, *Rape and the Culture of the Courtroom* (New York UP 1999); S Lees, *Ruling Passions: Sexual Violence, Reputation and the Law* (Open University Press 1997); J A Allison and L S Wrightson, *Rape: The Misunderstood Crime* (Sage 1993), J Busfield, 'The Female Malady? Men, Women and Madness in Nineteenth Century Britain' (1994) 28(1) *Sociology* 259.

¹⁸⁵ J Forrester, 'Rape, Seduction and Psychoanalysis' in S Tomaselli and R Porter (eds), *Rape: An Historical and Social Enquiry* (Basil Blackwell, 1986) 57-83, E Kanin, 'False Rape Allegations' (1994) 23 *Archives of Sexual Behaviour* 81, citing psychiatrist Karl Menninger as quoted in J Wigmore, *Evidence in Trials at Common Law* (Little Brown, 1940).

and popular discourse.¹⁸⁶ Female sexuality was connected to insanity and this fit within the conceptual framework of women as either ‘mad or bad.’¹⁸⁷ The mad woman was typically condemned for being in possession of a dangerous desire that men ought to be wary of.¹⁸⁸

During this time, women dominated mental illness statistics.¹⁸⁹ The disease of ‘hysteria’ most clearly demonstrates the link between women’s sexuality and madness. Hysteria is a female condition; the etymology of ‘hyster’ refers to the uterus and the condition has traditionally been associated with a woman’s repressed sexual desire.¹⁹⁰ Symptoms include ‘patient... interaction with others characterised by inappropriately sexually seductive or provocative behaviour, a rapid shifting and shallow expression of emotions, and theatrically exaggerated emotion’.¹⁹¹ It follows that hysteria became a ‘metaphor for everything unmanageable in women’.¹⁹²

One can trace the relationship between allegations of rape and mental health to medical jurisprudence of the late nineteenth century. In 1883 a French physician asserted that ‘all women are hysterical and...every woman carries with her the seeds of hysteria.’¹⁹³ The nineteenth century is known also for the emergence of psychoanalysis and the writings of Sigmund Freud. Freud made a link between women’s hysteria and fabrications of sexual assault,¹⁹⁴ presenting female sexuality

¹⁸⁶ J Ussher, *Women’s Madness: Misogyny or Mental Illness* (Harvester Wheatsheaf 1991) 64. See also E Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980* (Virago Press 1987).

¹⁸⁷ S Edwards, *Female Sexuality and the Law* (Martin Robertson 1981) 52.

¹⁸⁸ P Martin, *Mad Women in Romantic Writing* (Harvester, 1987) 14.

¹⁸⁹ J Ussher, *Women’s Madness: Misogyny or Mental Illness* (Harvester Wheatsheaf 1991) 71.

¹⁹⁰ I Veith, *Hysteria: The History of a Disease* (Chicago UP, 1965).

¹⁹¹ L Appignanesi, *Mad, Bad or Sad: A history of women and the mind doctors from 1800 to the present* (Virago Press 2008) 161.

¹⁹² M Micale, *Approaching Hysteria: Disease and Its Interpretations* (Princeton UP 1994) 191.

¹⁹³ Auguste Fabre quoted in E Showalter, ‘Hysteria, Feminism and Gender’ in Sander Gilman and others (eds), *Hysteria Beyond Freud* (University of California 1993) 286-7.

as relating to the subconscious mind, manifesting in ‘sexual fantasies of sexual domination, violation and rape’.¹⁹⁵

Freud rejected the idea that his female patients’ hysterical symptoms were a result of their history of sexual abuse, and instead believed that ‘they were only phantasies which my patients had made up’.¹⁹⁶ He argued that women were subject to erotic fantasies, and fantasies were in fact wishes¹⁹⁷. Taken a step further, Freud’s implication was that women could not be trusted to differentiate between their unconscious sexual desires and reality.¹⁹⁸ Because Freud’s work held sway, his theory was influential and became a common medical assumption.¹⁹⁹ Consequently, medical figures warned of women’s tendency to sexual delusion and the propensity of ‘neurotic individuals’ to transform ‘fantasies into actual beliefs and memory falsification.’²⁰⁰ During this period, the British False Memory society was created; scientists, doctors and other men came together to argue that memories could easily be changed by suggestion or wish – thus fears of false allegations of rape began to increase.²⁰¹

Such fear or belief of falsification of sexual complaints led legal scholars to call for evidentiary rules that allowed for the rigorous testing and careful scrutiny of rape complainants. For example, Machtinger argued that the admission of expert psychiatric evidence was necessary to protect innocent men from unfounded accusations:

¹⁹⁵ S Edwards, *Female Sexuality and the Law* (Martin Robertson 1981) 101.

¹⁹⁶ S Freud, ‘An Autobiographical Study’ in Peter Gay (ed), *The Freud Reader* (W W Norton 1989, 21).

¹⁹⁷ S Freud, ‘Creative Writers and Day-Dreaming’ in Peter Gay (ed), *The Freud Reader* (W W Norton, 1989, 439).

¹⁹⁸ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 E & P 28, 29-30.

¹⁹⁹ J Miller, *Freud: The Man, His World, His Influence* (Weidenfeld and Nicolson 1972).

²⁰⁰ Karl Menninger (a psychiatrist) quoted in J H Wigmore, *Evidence in Trials at Common Law* (Little Brown 1940) 463-464.

²⁰¹ E Kanin, ‘False Rape Allegations’ (1994) 23 Archives of Sexual Behaviour 81, 84-87.

The fact that many of these charges stem from a psychopathic mind makes it essential that the rules of evidence permit complete investigation into the truth of the charges. The most useful kind of evidence in a sexual case is the opinions of psychiatrists, social workers and probation officers as to the moral and mental traits of the prosecutrix.²⁰²

This ongoing attitude of mistrust is illustrated in statement of influential evidence scholar Wigmore. Writing in the 1940s, he proposed that the criminal courts should order the psychiatric evaluations of rape complainants as a precondition to prosecution.²⁰³ He argued that women's 'psychic complexes are multifarious and distorted' and that this was often manifested through the incidental but direct expression of the 'narration of imaginary sex-incidents of which the narrator is the heroine or victim.'²⁰⁴ Wigmore ensured the issue of credibility remained a central part of women's testimony when he declared that 'no judge should ever let a sex offence charge go to the jury unless the female complainant's social history and mental make-up have been examined and testified to by a qualified physician.'²⁰⁵ Such attitudes began to permeate the common law jurisdictions and evidential rules encouraged the testing and scrutiny of rape complainants.²⁰⁶

²⁰² S Matchinger, 'Psychiatric Testimony for the Impeachment of Witnesses in Sex Cases' (1949) 39(6) *Journal of Criminal Law & Criminology* 750.

²⁰³ J H Wigmore, *Evidence in Trials at Common Law*, (Little Brown 1940) 459-60.

²⁰⁴ Cited in S Leahy, 'The Corroboration Warning in Sexual Offence Trials: Final Vestige of the Historic Suspicion of Sexual Offence Complainants or a Necessary Protection for Defendants?' (2014) 18 *E & P* 41.

²⁰⁵ J H Wigmore, *Wigmore on Evidence, volume IIIA* (Little Brown & Co, 1937 – reprinted and edited by Chadbourne in 1970) 924a.

²⁰⁶ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 *E & P* 28, 30. For further discussion on the link between legal scepticism and the rules of evidence see also R Hunter, 'Gender in Evidence: Masculine Norms vs. Feminist Reforms' (1996) 19 *Harvard Women's Law Journal* 127-167; S Lees, *Ruling Passions: Sexual Violence, Reputation and the Law* (Open University Press 1997); M MacCrimmon, 'The Social Construction of Reality and the Rules of Evidence' (1991) 25 *British Columbia University Law Review* 36; C MacKinnon, *Feminism Unmodified: Discourses on Life and Law* (Cambridge MA Harvard UP 1987); J Temkin, *Rape and the Legal Process* (2nd edn, OUP 2002).

Similar views continued to be expressed in England and Wales during the 1960s and are reflected in the writing of Glanville Williams. He said '[e]xperience has shown that 'the complainant's evidence (in sexual cases) may be warped by psychological processes which are not evident to the eye of common sense.'²⁰⁷ He suggested that rape complainants should take a lie detector test. Evidence textbooks from this era stated that the danger of 'false accusations may proceed from all kinds of psychological neuroses and delusions.'²⁰⁸ This is not to say that due to the presence of a mental health issue the allegation was automatically deemed a false one. Rather that when present, mental health was a factor affecting how an allegation was viewed.

Nevertheless, the suggestion that women lack credibility and that there is a link between this view and the complainant's mental health remains. While hysteria is no longer recognised as a mental disorder, questions about a rape complainant's health may still lead to an inference being drawn between female psychopathology, mental illness and the stereotypical hysterical woman.²⁰⁹ Consequently, a connection endures between the veracity of the complainant's allegation and her mental health. Ellison argues this association endures to the present day and provides the foundation for the defence to pursue information about the complainants' mental health as a way of discrediting her account of events.²¹⁰ While such attitudes are no longer so openly expressed and such views do not dominate or operate in court today, i.e. that women are prone to fantasy, likely to make up allegations, and so on,

²⁰⁷ G Williams, 'Corroboration – Sexual Cases' [1962] Crim LR 662 at 663; see also 'Corroborating Charges of Rape' (1967) 67 Columbia Law Review 1137 and S Leahy, 'The Corroboration Warning in Sexual Offence Trials: Final Vestige of the Historic Suspicion of Sexual Offence Complainants or a Necessary Protection for Defendants?' (2014) 18 E & P 41.

²⁰⁸ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) E & P 28, 31 quoting *Heydon's Evidence: Cases & Materials* (Butterworths 1975) 81.

²⁰⁹ T Wilkinson-Ryan, 'Admitting mental health evidence to impeach the credibility of a sexual assault complainant' (2005) 153 University of Pennsylvania Law Review 1373, 1389.

²¹⁰ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 29.

the historic association between false complaints and mental health provides an important legal background and context to trials today.

It also explains why the defence would seek to use material relating to the complainant's mental health at trial. When defence counsel question a complainant about her psychiatric history or seek to adduce evidence relating to mental health, they are doing so in order to undermine her credibility. This is likely to prove effective 'because it invokes the gender stereotyped image of a mentally unstable accuser.'²¹¹ Raitt and Zeedyk propose that this theme of the mendacious woman making false accusations of rape continues to resonate:

Tactics to discredit rape victims are a feature of adversarial litigation throughout the common law world, where the principal objective in the cross-examination process appears to be to underline a belief in the tendencies of women to mislead and prevaricate in matters relating to sex. The tactics are underpinned by a remarkably tenacious social mythology that has become embedded in legal discourse.²¹²

The medical jurisprudence referred to above highlights how the criminal justice system in the past has deemed women inherently unreliable and incapable of telling the truth about their experiences. Certain evidentiary rules such as corroboration, which required independent evidence to substantiate an allegation, illustrate the existence of the assumption that a woman's word could not be trusted when it came to an allegation of rape.²¹³ 'The law's distrust of women's credibility, especially in regard to sexual matters, owes much to the framework of evidentiary rules within

²¹¹ Ibid 31.

²¹² F Raitt and M Zeedyk, 'False Memory Syndrome: Undermining the Credibility of Complainants in Sexual Offences' (2003) 26 *International Journal of Law and Psychiatry* 453, 458.

²¹³ J Temkin, *Rape and the Legal Process* (2nd edn, OUP 2002) 119.

which testimony can be heard.’²¹⁴ This statement was made in the context of trial. Problems can arise in instances where the complainant refuses to allow information about her mental health to be disclosed to the defence. Such refusal can have implications for the success of the prosecution. (As a starting point, however, it is arguable whether the substantive content of the material is relevant in the first place. This issues is considered in full detail in Chapter 6.) The important point is that in light of this historical context, a link exists between women’s mental instability and a perceived potential or likely fabrication of the rape allegation, the historical assumption being that women ought not to be trusted to speak the truth and so their evidence requires further support.

Conclusion

This chapter examined what constitutes a mental health condition and used bipolar as a general example of how the condition and its symptoms can be relevant within the criminal justice process. There exists a general societal stigma associated with mental health and this exists beyond the legal system. This is obviously critical for rape complainants with mental health issues, as it will influence their decision to inform others, e.g. the police, of the condition. With such a general societal stigma, and the fact the evidence of a mental health condition is deemed relevant by legislation in England and Wales, it seems germane to closely examine what happens when a mental health condition, such as bipolar, intersects with the criminal justice process.

Bipolar is illustrative generally of the important elements of a mental health condition i.e. these conditions exist on a spectrum, there a variety of causes and

²¹⁴ F Raitt, ‘Expert Evidence as Context: Historical Patterns and Contemporary Attitudes in the Prosecution of Sexual Offences’ (Case Note) (2004) 12 *Feminist Legal Studies* 233, 238.

symptoms. The most critical is that those symptoms have an associated risk when interacting with the judicial process. Through an examination of the interaction of the bipolar disorder and the judicial system, the chapter shows that a mental health condition clearly has the ability to have an impact on and negatively affect investigative and judicial proceedings. This impact comprises of how the complainant appears to the police, CPS or jury and how she is able to communicate her account of events. The impact also has different consequences, such as the complainant's ability and wiliness to engage with the police investigation and continue with support from the prosecution.

This chapter shows that when looking at the symptoms common to many mental health disorders and comparing them to relevant considerations in a judicial process, e.g. credibility and the complainant's ability to withstand the criminal justice process, it is clear that the mental health condition is likely to have an effect. Further, the chapter demonstrates that when we examine mental health conditions closely – there is a significant potential to develop policy recommendations that could contribute towards influencing the progress of a complaint. Upon this basis, a closer scrutiny of the effects of mental health on attrition rates is justified. A more detailed analysis of that potential impact at specific stages of the criminal justice process is explored in the remaining chapters, with the thesis overall following the progression of a case from report to trial. The next chapter looks at the issue of reporting an allegation of rape to the police and how the complainant may be reluctant to inform the police of having a mental health condition and the consequences this has on the progression of the case.

CHAPTER 3: Police Treatment of Rape

Complainants with Mental Health Issues at Initial

Reporting of Allegation

‘It is essential to point out that analysis of attrition in respect to rape allegations made by complainants with mental health issues will necessarily be based on cases identified by the police (or perhaps later by a prosecutor) as involving a complainant with a mental health issue.’²¹⁵

Introduction

This chapter concerns the investigative stage of the criminal justice process. It considers vulnerable complainants, specifically those with mental health conditions, and examines how the initial reporting and early investigation of the allegation can present challenges for both the vulnerable complainant and the police, in two crucial ways:

- Firstly, for the complainant in terms of informing the police that she has a mental health issue; and
- Secondly, for the police in terms of identifying that the complainant has a mental health issue.

The repercussions of both of these challenges are that complainants may not receive appropriate, i.e. sensitive, treatment that takes into account their situation, which in

²¹⁵ L Ellison, V Munro, K Hohl and P Wallang, ‘Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation’ (2015) 15(2) *Criminology & Criminal Justice* 225, 231.

turn can feed into attrition rates or indeed result in the crime not being reported (and so not entering the criminal justice system) at all.

This initial investigative stage is critical because it affects the complainant's involvement with the criminal justice system. The police are the initial gatekeepers to the criminal justice process – the decision to make a report to the police is merely the first and one of the only steps (excluding a decision to withdraw) that the complainant takes herself.²¹⁶ Sensitive and respectful treatment of the complainant is of particular relevance at this stage of the investigation because complainant withdrawal occurs most frequently at the early stages of investigation.²¹⁷ This is especially important since, as the discussion of the literature in Chapter 1 shows, negative experiences and interactions with the police are factors contributing to complainants with mental health issues withdrawing from the criminal justice process.

Once the allegation of rape is reported, the complainant's role is reduced to that of a witness and it is the police and CPS who take responsibility for the progression or discontinuance of the case. This can generate difficulties for all rape complainants, particularly where they are inadequately supported as vulnerable witnesses, potentially left out of communications in relation to the progression of their case or

²¹⁶ C Hanly, D Healy and S Scriver, *Rape and Justice in Ireland: A National Study of Survivor, Prosecutor and Court Responses to Rape* (Liffey Press 2009) 47.

²¹⁷ L Kelly, J Lovett and L Regan, *A gap or a chasm? Attrition in reported rape cases* (Home Office Research Study No 293, 2005), HMCPSI and HMIC, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSI, 2007), B Stanko and E Williams, 'Reviewing rape and rape allegations in London: what are the vulnerabilities of victims who report to the police?' In M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009) 207-225, V Stern, *Stern review of rape reporting in England and Wales* (London: Home Office 2010), M Hester, *From Report to Court: Rape cases and the criminal justice system in the North East*. Bristol: University of Bristol in association with the Northern Rock Foundation (2013).

‘dropped’ from the system as a result of others’ decision-making.²¹⁸ Rapport is a critical element influencing the willingness of the complainant to engage with the police. Relevant to this thesis, evidence exists of prejudicial attitudes regarding mental health within the criminal justice system in England and Wales, and shows that some decisions made by the police regarding case progression have been based on an incorrect understanding of mental health problems.²¹⁹ These attitudes have the potential to result in negative justice outcomes for complainants with mental health issues.²²⁰

This chapter has a two-part structure. Part I will examine current procedures in place for the investigative phase of a rape complaint. It will look at the specific provisions where the complainant is deemed a ‘vulnerable’ person, specifically a complainant with a mental disorder. It will examine the risks associated with vulnerability at the investigative stage and how they can affect complainant care and rates of attrition. It will consider the specific obligations placed on police and barriers on complainants, in the investigative stage in relation to mental health, and the ways in which the current system is flawed. For whilst the chapter acknowledges that there are guidelines and policies in place, it will posit that in practice there is a lack of training in these guidelines, and that the effects of policy implementation are slow to realise, which means ongoing detriment to mental health sufferers. Part II will consider briefly some positive initiatives in the field and how they are improving care and complainant experience.

²¹⁸ L Ellison and V Munro, ‘Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation’ 15(2) (2015) *Criminology and Criminal Justice* 225, 230.

²¹⁹ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

²²⁰ Mind, *Silenced Witnesses* (2001), A Watson et al., ‘Officers’ attitudes toward and decisions about persons with mental illness’ (2004) 55(1) *Psychiatric Services* 49.

Part I

This first part will step through the process experienced by complainants who report an allegation of rape to the police. It will then focus in on any additional obligations on police where the victim has a mental health condition. It will observe how these obligations play out in practice and describe the problems that can arise in and from the failure to identify that the complainant has a mental health condition early in the investigative stage of proceedings.

Early Stages of the investigative process – police treatment of rape complainants at initial reporting

The early stages of the investigative process of a rape offence include reporting and the First Responder, as well as attendance at a Sexual Assault Referral Centre and examination by the Forensic Medical Examiner. The general procedure for each of these stages is outlined below, followed by a discussion focussing on ‘vulnerable’ complainants, specifically those with mental health issues.

First Responder – general procedure

Of the complainants that report an allegation of rape to the police, the majority do so by telephone.²²¹ This means that a substantial percentage of rape complainants enter the process through self-report, rather than through police detection. Following receipt of this call, the police will dispatch a uniformed officer to the complainant, known as a ‘First Responder’. In a rape investigation, the complainant is initially met by this First Responder before she is introduced to a police officer specialising in Sexual Offences Investigative Techniques (SOIT, discussed further below).

²²¹ ACPO, NPIA and CPS, *Guidance on Investigating and Prosecuting Rape* (2010) 17 [http://library.college.police.uk/docs/acpo/Guidance-Investigating-Prosecuting-Rape-\(Abridged-Edition\)-2010.pdf](http://library.college.police.uk/docs/acpo/Guidance-Investigating-Prosecuting-Rape-(Abridged-Edition)-2010.pdf)

The role of the First Responder is three-fold: take initial details and samples from the complainant, inform the station to dispatch an SOIT officer and take the complainant to the Sexual Assault Referral Centre (SARC).²²² If the offence is alleged to have taken place within seven days of reporting, known as ‘the forensic window’, then samples are taken because there is a possibility of recovering forensic evidence from the complainant.²²³ In a study of over 1000 allegations in 2013/14, 43% were found to be within the seven-day forensic window, which indicates how many complainants could potentially attend an SARC.²²⁴ First Responders carry an ‘Early Evidence Kit’, which is used to obtain non-intimate samples including urine, hand and nail swabs, mouth swabs and clothing.²²⁵

Part of the function of the First Responder is to take initial details of the offence relating to what happened, where, when and who was responsible. The First Responder takes any immediate steps necessary to ensure the safety of the complainant, secures evidence, and locates and arrests the suspect (if appropriate and possible). The First Responder will ask the complainant questions – these will be general, open questions about the complainant, the offence and the suspect. The questions asked are not detailed, the aim is to obtain basic information and to avoid influencing or contaminating the complainant’s account.²²⁶ The First Responder officer will take notes of this initial conversation, and if the allegation proceeds to

²²² E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [226].

²²³ The Faculty of Forensic and Legal Medicine, ‘Recommendations for the collection of forensic specimens from complainants and suspects’ <www.fflm.ac.uk/wp-content/uploads/2017/01/Recommendations-for-the-collection-of-forensic-specimens-from-complainants-and-suspects-FSSC-Jan-2017.pdf> [accessed Mar 2017].

²²⁴ E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [324].

²²⁵ This is critical to ensure evidential opportunities; however, loss of evidence is common at this stage with critical consequences.

²²⁶ ‘From Report to Court: A Handbook for Survivors of Sexual Violence’ (Rights of Women 2014) 39. <<http://rightsofwomen.org.uk/wp-content/uploads/2014/10/PDF-of-From-Report-to-Court-a-handbook-for-adult-survivors-of-sexual-violence.pdf>> accessed July 2016.

court, the record of these notes will be used as part of the prosecution's case.²²⁷ At this stage, a decision must be made as to whether a crime should be recorded. Unless there is credible evidence to the contrary, then the First Responder should record that crime.²²⁸ It used to be the case that the First Responder could make the decision to 'no crime' the initial report, i.e. to decide that no crime had occurred. This decision was made on the basis either that a crime was recorded in error, or that there was 'additional verifiable information' that no crime had occurred. This is no longer allowed because police were 'no criming' allegations when they should not have been²²⁹; First Responders were classifying reports as false allegations, which was problematic (and wrong).²³⁰ Because the allegation is at such an early stage, it is not possible to determine whether a crime has occurred; a proper investigation has not been conducted yet and it is not the role of the First Responder or the SOIT officer to make evaluations of the case prior to investigation.²³¹

As described above, the focus of the First Responder lies in capturing general information of the alleged rape incident as reported by the complainant. The First Responder is trained in the use of Early Evidence Kits but is also meant to have an

²²⁷ Ibid.

²²⁸ Home Office Counting Rules for Recorded Crime

<https://www.gov.uk/government/publications/counting-rules-for-recorded-crime>, HMIC, The Crime Recording Process <www.justiceinspectorates.gov.uk/hmic/our-work/crime-data-integrity/crime-recording-process/>.

²²⁹ HMIC and HMCPSI, *Without Consent. A Report on the Joint Review of the Investigation and Prosecution of Rape Offences* (London: HMCPSI and HMIC, 2007).

²³⁰ HMIC, *Crime-Recording: Making the Victim Count, The final report of an inspection of crime data integrity in police forces in England and Wales* (November 2014) www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/crime-recording-making-the-victim-count.pdf [accessed Sep 2015], HMIC, Crime Data Integrity. Inspection of the Metropolitan Police Service (2014), HMIC, 'Victims let down by poor crime recording' (press release) www.justiceinspectorates.gov.uk/hmic/news/news-feed/victims-let-down-by-poor-crime-recording/ accessed September 2015.

²³¹ As prescribed by the Metropolitan Police Sapphire SOIT officer 'Toolkit'.

in-depth understanding of the possible complexities of a complainant's behaviour following a sexual offence.²³²

A critical time to establish rapport

In reporting the allegation, the complainant's first contact with the police is likely to be with the First Responder. Complainants have described this encounter as a 'make or break stage'.²³³ This time is crucial, not only for capturing evidential opportunities, but in giving the complainant confidence in the criminal justice process.²³⁴ This encounter will influence how the complainant engages with the rest of the criminal justice process. Consequently, the way in which the First Responder interacts with the complainant is critical.²³⁵ Trust may be lost if the police officer expresses an attitude of scepticism or disbelief towards the complainant and her account. This can lead the complainant to withdraw from the process and retract the allegation altogether, thereby contributing to the rate of attrition.²³⁶ Research supports the statement that trust in the police and a willingness to continue with the allegation is lost when the police officers show a lack of belief or respect.²³⁷ Many rape allegations are withdrawn soon after reporting to the police – approximately 47.5% of attrition at the reporting stage is due to victim withdrawal.²³⁸

²³² ACPO, NPIA and CPS, *Guidance on Investigating and Prosecuting Rape* (2010) 45 [http://library.college.police.uk/docs/acpo/Guidance-Investigating-Prosecuting-Rape-\(Abridged-Edition\)-2010.pdf](http://library.college.police.uk/docs/acpo/Guidance-Investigating-Prosecuting-Rape-(Abridged-Edition)-2010.pdf) [accessed June 2016].

²³³ J Jordan, 'Beyond Belief? Police, Rape and Women's Credibility' (2004) 4(1) *Criminal Justice* 29, E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) paras [230], [218], [213].

²³⁴ *Ibid* para [13].

²³⁵ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

²³⁶ HMCPSI and HMIC, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSI, 2007).

²³⁷ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

²³⁸ E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [230].

The SOIT officer – role and general procedure

The SOIT officer takes over from the First Responder, either taking the complainant to or meeting at the SARC. Their primary role and responsibility during these early stages is to assist at the SARC and then to conduct the Achieving Best Evidence (ABE) interview.²³⁹ The SOIT is intended to be the single point of contact for the complainant for the entire investigative and prosecutorial process – keeping the complainant updated on case developments, providing support to the complainant in the form of information about the criminal justice process, or information about other organisations that can assist the complainant. The SOIT is also the single point of contact between the complainant and the investigative team; this makes the role ‘central to the investigation process and maintaining the complainant’s confidence’.²⁴⁰ The SOIT is involved in the investigation of the case but the person with the overall responsibility for the case is the Investigating Officer (IO).

SARC and the Forensic Medical Examination – general procedure

One of the responsibilities of the police is to liaise with the SARC to arrange a forensic medical examination for the complainant.²⁴¹ An SARC is open 24 hours a day and is run by charities with the support of local partnerships and NHS Trusts.²⁴² SARCs are ‘one stop locations where complainants receive medical care and counselling from expert practitioners, and have the opportunity to assist the police investigation, including undergoing a forensic examination.’²⁴³ If the complainant decides, independent of police involvement, to go to an SARC, i.e. to self-refer, she can obtain a forensic medical examination without having to decide whether to

²³⁹ This interview is the subject of the next chapter.

²⁴⁰ E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [265].

²⁴¹ In London, a SARC is called a Haven.

²⁴² The Survivor’s Trust <http://thesurvivorstrust.org/>

²⁴³ Cross Government Action Plan on Sexual Violence and Abuse April 2007.

report the offence to the police. In London, the police are responsible for 90% of referrals to various SARCs.²⁴⁴ Studies have shown that if a complainant attends a SARC, the prospect of attrition is halved.²⁴⁵ Evidently, this is a critical stage in the investigative process.

Upon arrival, the complainant is taken through the process of what happens at the SARC, including an explanation of the examination itself, use of samples, consent etc. The forensic physician, also known as a Forensic Medical Examiner (FME) is the medical doctor that conducts the examination. The FME is an independent expert who works on behalf of the courts and is non-partisan. The purpose of a forensic medical examination is to obtain physical evidence that may be of use in a subsequent investigation or criminal trial.²⁴⁶ The FME needs to obtain informed consent from the complainant to conduct the examination. The FME explains what will happen during the examination. Documents published by a SARC in Manchester emphasise that it is important to ensure that the complainant feels in control of what is taking place, and that nothing is done without her consent.²⁴⁷ For that reason, the complainant can consent to some parts of the examination and not others. The examination involves gathering all traces of any bodily fluid, skin or hair left by the suspect and so any samples of hair are collected, and swabs taken from the complainant's nails and mouth. The complainant may be asked to give a blood or

²⁴⁴ In 2013/14 only 115 people or 11% of the clients attending the haven in London were self-referrals - this is a very low number considering the number of total allegations made that year were 5577. E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [376].

²⁴⁵ E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [14], K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

²⁴⁶ C Halloran 'From Report to Court: A Handbook for Survivors of Sexual Violence' (Rights of Women 2014) 32. <<http://rightsofwomen.org.uk/wp-content/uploads/2014/10/PDF-of-From-Report-to-Court-a-handbook-for-adult-survivors-of-sexual-violence.pdf>> [accessed July 2016].

²⁴⁷ St Mary's Sexual Assault Referral Centre: Annual Report 2012-2013, 6 <https://www.stmaryscentre.org/application/files/4414/7793/0585/12-19544-SARC-Annual-Report-2013.pdf>

urine sample, particularly if the complainant had consumed drugs or alcohol or is concerned that they have been deliberately drugged. The complainant is also examined for physical injuries such as cuts and bruises; any injuries that are found will be recorded (photographed if visible). The FME may ask intimate questions (if the complainant is taking the pill, when the last menstrual cycle was, whether the complainant uses contraceptives) in order to determine the risk of the complainant becoming pregnant.

The FME is required to make a report for the courts.²⁴⁸ If the complainant attends the SARC directly, without contacting the police, she decides what happens to the forensic evidence. However, if the complainant attends the SARC with the police, and consents to the examination, the police keep the forensic evidence taken during the FME for their investigation; the results and any other information provided will be police evidence.²⁴⁹ In this instance, if the complainant agrees to the forensic medical examination she is agreeing that the results and the evidence gathered are given to the police.²⁵⁰

The FME compiles a medical report on the examination. There is also the option/choice to include information about the complainant's medical history on the confidential medical record. This means that there are two sets of records at play, i) forensic medical records and ii) confidential medical records. The medical report of the examination conducted at the SARC is the forensic medical record and is disclosable to the court. Any part of that report that concerns the complainant's

²⁴⁸ B Ryan, 'The Work of a Sexual Assault Referral Centre' in J Pritchard, *Good Practice in Promoting Recovery and Healing for Abused Adults* (Jessica Kingsley Publishers 2013) 72.

²⁴⁹ The Havens, 'Forensic Medical Examination' www.thehavens.org.uk/visiting-us/what-happens-at-the-havens/forensic-examination/

²⁵⁰ C Halloran, 'From Report to Court: A Handbook for Survivors of Sexual Violence' (Rights of Women 2014) 36-7. <<http://rightsofwomen.org.uk/wp-content/uploads/2014/10/PDF-of-From-Report-to-Court-a-handbook-for-adult-survivors-of-sexual-violence.pdf>> [accessed July 2016].

medical history is a confidential medical record. This document and its use is discussed in Chapter 5: Disclosure and Mental Health Evidence. It can be difficult to determine what information may be relevant as part of the (police) investigation and if the FME considers information sensitive, such as relating to a mental health issue, this can be entered as part of the confidential medical record. The FME will discuss this issue with the complainant as part of gaining consent.²⁵¹ The FME will explain to the complainant what will happen regarding these records if the case proceeds to court. In addition to the complainant's forensic medical records, the confidential medical records may be given to the defence. The FME will not breach confidentiality unnecessarily but if the court orders disclosure, the FME does not have a choice. The complainant's doctor will always seek to inform the complainant and to obtain consent before such disclosure occurs.²⁵²

The entire process at the SARC takes approximately two to three hours, after which the police usually escort the complainant home. An interview with the complainant is generally conducted the next day or in coming days, depending on the physical and mental state of the complainant. Additional services are offered to the complainant at the SARC – this includes housing support and counselling. The complainant has the option of counselling which includes six sessions with a clinical psychologist.²⁵³

The above discussion illustrates that the early investigative phase of a rape allegation is critical. The skills of, and the rapport established by, the police First Responder and the SOIT officer are crucial to the complainant. They are the first point of

²⁵¹ B Ryan, 'The Work of a Sexual Assault Referral Centre' in J Pritchard, *Good Practice in Promoting Recovery and Healing for Abused Adults* (Jessica Kingsley Publishers 2013) 74.

²⁵² General Medical Council, *Confidentiality: good practice in handling patient information* (Jan 2017) 16 http://www.gmc-uk.org/Confidentiality2017.pdf_69037815.pdf [accessed Apr 2017].

²⁵³ The issue of pre-trial therapy is the subject of Chapter 6.

contact and the ongoing liaison and are determinative of whether the complainant engages in the criminal justice process. The next section will consider how a complainant with a mental health issue fits within this process.

SARC and the Forensic Medical Examination – complainants with mental health issues

It is worth noting that the issue of a complainant's mental health may also arise at the SARC when the medical examination takes place. Mental health issues therefore play a role in this stage of the investigative process. After the physical examination the FME may ask the complainant whether she is taking medication and whether she has a mental health issue.²⁵⁴ Furthermore, the complainant may be unable to give her consent to the medical examination due to reasons relating to mental health, intoxication or learning disabilities.

All SARC clients are assessed for vulnerabilities; as mentioned above in reference to Stanko and Williams' research, these include alcohol, drug use mental health issues and learning disabilities. In 2013/14, 803 clients who attended an SARC in London presented with 1201 vulnerabilities.²⁵⁵ This means that over half of the complainants attending a SARC present with one or more vulnerabilities. Alcohol was involved when the offence took place for 422 complainants (35%); it was the most frequently recorded vulnerability. The second most frequent vulnerability for 295 complainants (25%) was that of mental health issues. In these figures, vulnerabilities in fact outstrip the number of individuals, suggesting the frequency and complexity of the vulnerabilities in this group of complainants. This concludes the discussion of the early stages of the investigative process for rape complainants. In the next part I will

²⁵⁴ The physical aspect of the examination last approximately 20-30 minutes.

²⁵⁵ 56% of all forensic clients.

examine how the success of this process may be adversely affected by a complainant's mental health issues.

‘Vulnerable’ complainants and mental health –guidelines and policy

‘Government policy has increasingly been interested in the notion of ‘vulnerability’ to describe people with circumstances or conditions which make them less able to access the benefits or protections afforded to most other people within society.’²⁵⁶

Police in England and Wales are guided by several key documents regarding the proper treatment of all victims, outlining police responsibilities regarding victim and witness care. Relevant guidelines are the *Code of Practice for Victims of Crime* and *Witness Charter: Standards of Care for Witnesses in the Criminal Justice System*.²⁵⁷ They describe the overall victim-orientated approach that the police are meant to adopt: ‘[a]ll victims and witnesses are entitled to receive a high quality service from the police, from their initial contact with the first officer or member of police staff that they meet, throughout the investigation and beyond to the pre-trial and trial processes.’²⁵⁸

Both general and specific guidelines regarding victim care exist, including those that cater to those persons deemed ‘vulnerable’. As will be shown, people with mental health issues fall under the category ‘vulnerable’; a summary and analysis of identification and treatment of ‘vulnerable’ complainants is therefore warranted. This

²⁵⁶ *Access to Justice: a review of the existing evidence of the experiences of adults with mental health problems* (Ministry of Justice Research Series 06/09, 2009) 63.

²⁵⁷ Ministry of Justice (2015) and (2013).

²⁵⁸ Ministry of Justice, *Vulnerable and Intimidated Witnesses: A Police Service Guide* (March 2011) [foreword].

chapter predominantly refers to vulnerability in the context of and with reference to the complainant having a mental health condition or experiencing mental ill health. It will consider the issues this gives rise to for rape complainants in reporting the allegation. The effectiveness of policy documents is considered below.

The *Code of Practice for Victims of Crime* places an obligation on the police to identify ‘vulnerable or intimidated victims’. There is no single international agreed definition of who is a ‘vulnerable’ witness in an investigative setting.²⁵⁹ ‘Any one single definition of vulnerability based on age, incapacity, impairment or medical condition may not reflect the nature of the vulnerability that a particular individual may face a different times and in different environments.’²⁶⁰ Examples of vulnerability include adults with mental health issues or learning disabilities, elderly adults or young children. The term can also refer to particular circumstances such as being cared for by another person or being the victim of a specific crime.

The term ‘vulnerable or intimidated’ was defined by s16 YJCEA 1999 as encompassing victims and witnesses ‘whose quality of evidence is likely to be diminished because they are suffering from a mental disorder’ as defined by the Mental Health Act 1983 (MHA 1983) – and to provide them with enhanced support. The Mental Health Authorised Professional Practice (Mental Health APP), which is published by the College of Policing and came into effect on 6 October 2016, is the national police guidance for the appropriate approach to dealing with victims, witnesses and suspects with mental health issues. The Mental Health APP states that ‘the term mental ill health is used broadly to refer to all those matters relating to mental health problems. These include mental disorders, mental illness, mental

²⁵⁹ R Bull, ‘The investigative interviewing of children and other vulnerable witnesses: Psychological research and working/professional practice’ (2010) 15 *Legal and Criminological Psychology* 5.

²⁶⁰ Advocacy Training Council, ‘Identifying Vulnerability in Witnesses and Defendants: Toolkit 10’ (The Advocate’s Gateway July 2014) 2.

health needs and many of the issues that fall within the MHA 1983 definition of mental disorder.’²⁶¹ The disorder of bipolar that was examined in Chapter 2 and a majority of the disorders listed in the DSM-V would also fall within under the MHA 1983 definition. The term also encompasses complainants who are experiencing ‘mental distress’ at the time they come into contact with the police, whether or not they have been formally diagnosed or have previously received mental health services.

The intended effect of the Mental Health App and the *Code of Practice for Victims of Crime* is to focus on the initial point of contact between vulnerable complainants and the criminal justice system. These guidelines are intended to complement the *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures (ABE Guidelines)*, which describes good practice in the treatment of vulnerable victims from the investigation stage onwards.²⁶² The *ABE Guidelines* relate to interviewing of the complainant and special measures, which can support the complainant at trial.

These documents make clear that the ‘identification of a vulnerable witness at an early stage of an investigation is of paramount importance. It will improve the quality of an investigation by assisting the witness to give information to the police; it will assist the legal process by helping the witness to give their best evidence in court.’²⁶³ As set out in Chapter 1, this is understood in terms of the completeness, coherence and accuracy of the complainant’s account. It is clear that one objective of such guidance is to produce stronger cases, but a related purpose is to have the police

²⁶¹ College of Police, Mental Health APP <https://www.app.college.police.uk/app-content/mental-health/introduction-and-strategic-considerations/#specific-terminology> [accessed Dec 2016].

²⁶² Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures* (3rd edn, 2011).

²⁶³ Ministry of Justice, *Vulnerable and Intimidated Witnesses: A Police Service Guide* [1.7].

consider their conduct towards complainants and how this may also affect the investigative process and case progression in general.

*Vulnerable and Intimidated Witnesses: A Police Service Guide*²⁶⁴ prescribes good practice for police officers and sets out a number of prompts intended to aid the identification of victims who may be vulnerable.²⁶⁵ The College of Policing have also published guidance entitled *Working with Victims and Witnesses*. This document advises the police to set a ‘Victim/Witness Strategy’. This strategy consists of three elements: victim identification strategy, initial contact strategy and witness interview strategy. The police are meant to take into account the *Code of Practice for Victims of Crime* when dealing with vulnerable witnesses.²⁶⁶

For the purposes of the current discussion, it will be presumed that the complainant has self-presented to the police to report the rape. In terms of initial contact, the police must consider the manner in which they approach the complainant. This encompasses initial interaction and interview through to the conclusion of the prosecution case. Reference is made to victim care (i.e. satisfaction) as police treatment can affect how a complainant perceives the criminal justice process, whether she will report again, and is determinative of whether the complainant will withdraw from the process.²⁶⁷ Furthermore, these early interactions with police can affect the progression and success of the investigation itself and whether material and information relevant to the investigation is supplied to the police, thereby enabling the case to proceed.

²⁶⁴ Published March 2011.

²⁶⁵ It also sets out the special measures for which they may be eligible – although the topic of special measures in general is not the focus of this chapter.

²⁶⁶ The most recent version being published by the Ministry of Justice in 2015.

²⁶⁷ S Payne, *Redefining Justice: Addressing the individual needs of victims and witnesses* (London Home Office, 2009).

Mental Health in the context of rape allegations

In the investigative process of a rape case, mental health issues or learning disabilities are regarded as vulnerabilities. The police act as initial arbitrators of admission to the criminal justice system and yet, as has been seen elsewhere, if certain vulnerabilities are present decision-making can easily be affected by preconceived notions of those vulnerabilities. From entry into the criminal justice process, vulnerable complainants are disadvantaged by the circumstances of the rape itself.²⁶⁸ Stanko and Williams's research defines vulnerability as encompassing the age of the complainant (being under 18 years of age); having a noted mental health issue, currently or previously; being intimate with the offender; and having consumed alcohol or drugs prior to the offence.²⁶⁹ In the wider literature, having a mental health condition²⁷⁰ or having consumed alcohol prior to the attack²⁷¹ are both considered factors that are influential in case progression and/or outcome. Vulnerability then itself becomes a crucial test of potential evidence, as the police have to assess the perceived credibility of the complainant. This means the complainant's vulnerability is related to two matters. Firstly, vulnerability affects the complainant's exposure to victimisation. Secondly, vulnerability is a factor which is influential in determining the outcome of the case.

²⁶⁸ B Stanko and E Williams, 'Reviewing Rape and Rape Allegations in London: What are the Vulnerabilities of the Victims who Report to the Police?' in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009).

²⁶⁹ *Ibid* 214.

²⁷⁰ L Ellison, V Munro, K Hohl and P Wallang, 'Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation' (2015) 15(2) *Criminology & Criminal Justice* 225.

²⁷¹ E Finch and V Munro, 'Juror stereotypes and blame attrition in rape cases involving intoxicants' (2005) 45(1) *Brit J Criminol* 25–38, E Finch and V Munro, 'The demon drink and the demonised woman: Socio-sexual stereotypes and responsibility attribution in rape trials involving intoxicants' (2007) 16(4) *Social and Legal Studies* 591–614, J Lovett and M Horvath, (2009) 'Alcohol and drugs in rape and sexual assault' in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing, 2009) 125–160.

The *Code of Practice for Victims of Crime* and Mental Health App emphasise the importance of identification mental health issues. However, in practice, for reasons that will be outlined below, police struggle to make that identification. Identification can be two ways: self-identification by the complainant and police identification. However, despite the College of Policing producing new Mental Health APP guidelines, the problems in this area often relate to implementation of policy.²⁷² Although these new measures have recently been implemented, it may be some time before the changes are evident and the education and training filters in to practice.²⁷³

Barriers to self-identification of mental health issues by complainant

Koskela's research explores the experiences of complainants with mental health problems in accessing the criminal justice system, focusing on their experiences with the police.²⁷⁴ The research found evidence of experiences of stigma, discrimination and prejudice.²⁷⁵ The complainant's mental health issues were often felt to be a label that aroused stigma to the point that their reports were discredited and disbelieved. It follows that discrimination and prejudice experienced by complainants with mental health issues has the potential to inhibit help-seeking behaviour. The mental health charity Mind has drawn attention to the difficulties that people with mental health problems experience in reporting crimes and having the case prosecuted in court.²⁷⁶

²⁷² Home Office, *The Stern Review: A Report by Baroness Vivien Stern CBE of an Independent Review into how Rape Complaints are Handled by Public Authorities in England and Wales* (2010) 8.

²⁷³ The CPS undertook a comprehensive rape training programme in 2015-16. This was a result of the 2014 CPS and Police National Rape Action Plan designed to improve the investigation and prosecution of rape offences. According to the CPS Violence against Women and Girls 2015-16 Crime Report a majority of these recommendations have been implemented in the form of education, training and improvements to case work quality and treatment of victims.

²⁷⁴ S A Koskela et al., 'The experiences of people with mental health problems who are victims of crime with the police in England: A qualitative study' (2016) 56(5) *Brit J Criminol* 1014.

²⁷⁵ Stigma refers to the general negative stereotypes that exist within society associated with a condition, such as mental illness. Discrimination is being treated unfairly or denied opportunities. Prejudice is a public fear, misunderstanding an intolerance around mental health issues (SEU 2004).

²⁷⁶ M Pedlar et al., *Silenced Witnesses* (London: Mind 2000), *Another Assault* (Mind 2007).

Mind's research provides insight into the problem of disclosure,²⁷⁷ which it found was a particularly prominent issue for victims of rape and other sexual offences who have mental health issues. This reinforces findings from other studies of people with mental health issues.²⁷⁸ Negative or inaccurate perceptions about mental health may be preventing and deterring complainants with mental health problems from accessing justice as victims of crime.

Complainants can be reluctant to disclose victimisation because they anticipate a negative response from police. There is the recurring theme of a fear of not being believed due to the mental health issue. A number of complainants in Koskela's interviews described previous experiences of attempting to report crime(s) which were either not taken forward or did not result in a satisfactory outcome, and this acted as a deterrent from reporting subsequent incidents.²⁷⁹ This is a problem identified in the existing literature and illustrates how previous dealings with the police are highly influential in deciding whether to report the current allegation.²⁸⁰ Many complainants said they felt they had not been believed when they reported previous crimes because of their mental health issues. This is consistent with the earlier findings of Mind in 2007. Complainants with mental health issues have been described as being difficult to understand, confused or even delusional. The police

²⁷⁷ Ibid.

²⁷⁸ S Marwaha, 'Views and Experiences of Employment among People with Psychosis: A Qualitative Descriptive' (2005) 51(4) *International Journal of Social Psychiatry* 302, J Powell and A Clarke, 'Information in mental health: a qualitative study of mental health service users' (2006) 9(4) *Health Expectations* 359, C Roeloffs et al., 'Stigma and depression among primary care patients' (2003) 25 *General Hospital Psychiatry* 311, H Stuart, 'Mental Illness and Employment Discrimination' (2006) 19(5) *Current Opinion in Psychiatry* 522, B Schulze and C Angermeyer, 'Subjective experiences of stigma: a focus group study of schizophrenic patients, their relatives and mental health professionals' (2003) 56(2) *Social Science and Medicine* 299, W Gaebel and H Zanke, 'Intervening in a multi-level network: progress of the German Open the Doors projects' (2005) 4 (Supp 1) *World Psychiatry* 16.

²⁷⁹ S A Koskela, B Pettitt and V M Drennan, 'The experiences of people with mental health problems who are victims of crime with the police in England: A Qualitative Study' (2015) *Brit J Criminol* 6.

²⁸⁰ W Skogan, *Contacts between Police and Public: Findings from the 1992 British Crime Survey* (Home Office Research Study 134, 1994), Z MacDonald, 'Revisiting the Dark Figure: A Microeconomic Analysis of the under-reporting of Property Crime and Its Implications' (2001) 41 *Brit J Criminol* 127.

saw their stories as inconsistent and did not proceed with the investigation. An illustration can be seen in Hester's research. In one case, paramedics had been called by the complainant's brother 'due to her state of mind'; the paramedics contacted the police when the complainant mentioned she had been raped. The police recorded that 'she was very difficult to understand and was rambling about random matters but kept returning to the rape'. The complainant alleged that she had been raped by two ex-partners, whom she said visited her as demons. The police officer did not believe that there was any credibility to the claims. The complainant was subsequently taken to the local mental health unit for 'professional advice and treatment' but the case did not proceed any further.²⁸¹

Section 136 of the MHA 1983 allows police to take individuals who are suffering from a mental health problem in a public place to a 'place of safety' for their own protection, or the protection of others, for up to 72 hours. Police stations are only meant to be used as a place of safety in 'exceptional circumstances'. However, there may not be an appropriate place at the station to detain the complainant; police cells are often the only available option and are certainly not equipped to support the needs of those with mental health problems. Placement in a police cell 'criminalises' people with mental health problems, potentially causing further distress.²⁸² Many complainants are fearful of disclosing victimisation for fear of being detained like this under s136. An example of a positive partnership between the police and mental health services is provided by Leicestershire Police, who have two officers based in a local hospital with a psychiatric unit. Being based at the hospital has helped to improve multi-agency coordination between the police and mental health

²⁸¹ M Hester, *From Report to Court: Rape Cases and the criminal justice system in the North East* (July 2013 University of Bristol and Northern Rock Foundation) 13.

²⁸² Mind, *Police and Mental Health: How to get it right locally* (ACPO 2013) 26.

professionals, enhancing relationships and providing opportunities for effective information sharing. The initiative has helped to remove communication barriers and build positive relationships between mental health complainants and the police, particularly those persons whose only previous contact with the police was being detained under s136 MHA 1983.²⁸³

Having experiences acknowledged, validated and taken seriously is critical for all rape complainants, but most particularly for those with mental health issues. When a complainant discloses a mental health problem, the experience will be more positive if the police show empathy and understanding and make reasonable adjustments where appropriate.²⁸⁴ However, if the police make insensitive or judgemental remarks, respond poorly to distress and fail to provide appropriate support, this will result in a negative experience for a complainant.²⁸⁵ Some complainants said they felt blamed for the incident e.g. being told they must have done something to provoke the defendant or to change their behaviour after the crime, thereby implying culpability or blame on the part of the complainant. The rates of re-victimisation of complainants with mental health problems are concerning.²⁸⁶ Their attackers often target complainants with mental health issues because it is known the complainant is unlikely to report an offence.²⁸⁷ This reluctance places the complainant at an

²⁸³ Ibid.

²⁸⁴ B Pettitt et al., *At Risk Yet Dismissed: The Criminal Victimisation of People with Mental Health Problems* (London: Victim Support/Mind 2013).

²⁸⁵ E Angiolini, *Report of the Independent Review into the Investigation and Prosecution of Rape in London* (April 2015) para [220],

²⁸⁶ Ibid.

²⁸⁷ N Burrowes, 'Responding to the Challenges of Rape Myths in Court' (NB Research: London 2013) 17 <http://nb-research.co.uk/wp-content/uploads/2013/04/Responding-to-the-challenge-of-rape-myths-in-court_Nina-Burrowes.pdf>

increased risk of victimisation. For this reason, the police need to work to improve confidence in their services.²⁸⁸

Barriers to identification by police of complainants with mental health issues

Police officers play a crucial role in working with and supporting complainants with mental health issues. Although the complainant may report an allegation of rape to a close friend or family member, the police are likely to be the complainant's first point of official contact with the criminal justice system. The police also may be the first to respond to urgent situations involving persons with mental health problems.²⁸⁹ It has been the case in the past that the presence of certain factors precluded the complainant from being considered credible. For example, some vulnerabilities may mean the complainant has particular difficulties with communication or receiving information. As shown in the documents and guidelines described above, steps have been taken to alter this perception and the criminal justice system does seem to be striving for better support and accommodation of complainants who are vulnerable.²⁹⁰ This encompasses both the police and the investigative stage and the trial/prosecution itself. However, this is not always successful and not as fully integrated nor a part of the culture as it could be.

²⁸⁸ M Pedlaret al., *Silenced Witnesses* (London: Mind 2000); J S Brekke et al., 'Risk for individuals with schizophrenia who are living in the community' (2001) 51 *Psychiatric Services* 1358.

²⁸⁹ Mind, *Police and Mental Health: How to get it right locally* (ACPO 2013).

²⁹⁰ This is evidenced in the Toolkits published by the Inns of Court College of Advocacy, for example, 'Ground rules hearings and the fair treatment of vulnerable people in court', 'General principles from research, policy and guidance: planning to question a vulnerable person or someone with communication needs'. There are also specific toolkits for persons with autism spectrum disorder, learning disability, traumatised witnesses, the young and those with a mental disorder <www.theadvocatesgateway.org/toolkits>.

The research suggests that police have difficulty identifying vulnerable and intimidated witnesses in practice and this is particularly true for individuals with mental health issues.²⁹¹ This may be the result of a combination of two factors:

- Firstly, the culture of scepticism²⁹²; a trait commonly associated with police investigators in sexual violence cases;²⁹³ and
- Secondly, the perceived lack of training when it comes to identifying and dealing with mental health issues.

The problems involving disclosure and identification of mental health conditions during the investigative stage, will now be explored, along with ramifications of such failure to identify (i.e. the effect on the complainant and the complaint).

It may be the case that the police are not familiar with various types of particularly vulnerable complainants. This is important not only in terms of the police trying to understand what it is a complainant wishes to convey and police being understood by the complainant, it is also important in terms of a police officer's reaction to vulnerable people.²⁹⁴ Research has shown that when people meet others with whom they are unfamiliar, their own behaviour may well become abnormal.²⁹⁵ This unusual behaviour is often noted by vulnerable people who may view it as a sign of

²⁹¹ M Burton, R Evans and R Sanders, 'Vulnerable and Intimidated Witnesses and the Adversarial Process in England and Wales' (2007) 11(1) E & P 1, M Burton and A Sanders, *An evaluation of the use of special measures for vulnerable and intimidated witnesses* (Home Office 2006).

²⁹² This is discussed in Chapter 4 in the context of the complainant's interview with police.

²⁹³ L Kelly, 'The (In)Credible Words of Women: False Allegations in European Rape Research' (2010) 16(2) *Violence against Women* 1345, 1347, J Brown, C Hamilton and D O'Neill, (2007) 'Characteristics associated with rape attrition and the role played by scepticism or legal rationality by investigators and prosecutors' (2007) 13(4) *Psychology, Law and Crime* 355.

²⁹⁴ R Bull, 'The investigative interviewing of children and other vulnerable witnesses: Psychological research and working/professional practice' (2010) 15 *Legal and Criminological Psychology* 5, 16.

²⁹⁵ W Heinemann, 'Meeting the handicapped: A case of affective-cognitive inconsistency' (1990) 1 *European Review of Social Psychology* 323.

discomfort.²⁹⁶ For this reason police need to be aware that while they may intentionally try to act in a friendly and helpful way to vulnerable complainants, they may at the same time unwittingly give contradictory signals of unease and/or embarrassment, anxiety etc. including feelings of their own insecurity about handling the situation.

Guidance produced by The Association of Chief of Police Officers (ACPO) in 2010 recognises that symptoms of mental health issues may not be immediately obvious, or that they may co-exist with other vulnerabilities to which symptoms of mental health issues may be easily misattributed, such as intellectual disability or substance misuse.²⁹⁷ Where there is coexisting substance misuse, there is a risk that serious mental ill health may go unrecognised, as ‘sometimes psychotic symptoms and challenging behaviour will be attributed solely to the substance use.’²⁹⁸ Although substance abuse is still a ‘vulnerability’, it is not the misappropriation that will lead the complainant not being classified as vulnerable. Rather, the point is that the classification of the vulnerability is incorrect and the needs of someone with substance abuse issues can be very different from the needs of someone with schizophrenia. Consequently, many complainants with a mental health issue may not have their needs assessed.²⁹⁹ This can relate to simple care measures such as a need for a break during interview and offers of assistance in obtaining support. All of these problems are further compounded by the reported reluctance of some complainants to disclose a mental health issue for fear that their condition may be

²⁹⁶ L Coleman and B DePaulo, ‘Uncovering the human spirit: Moving beyond disability and ‘missed’ communications’ in N Coupland, H Giles, J Wiemann (eds) *Miscommunication and Problematic Talk* (Sage 1991) 61-84.

²⁹⁷ ACPO was dissolved in 2015 and was replaced by the National Police Chiefs’ Council.

²⁹⁸ ACPO, *Guidance on responding to people with mental ill health or learning disabilities* (London: ACPO 2010) 22.

²⁹⁹ M Burton, R Evans and R Sanders, ‘Vulnerable and Intimidated Witnesses and the Adversarial Process in England and Wales’ (2007) 11(1) E & P 1

misunderstood, or have an adverse impact on their credibility. In surveys, individuals have reported that they would be more likely to disclose their condition if asked a direct question and given some reassurance about the potential uses of this information within the criminal process.³⁰⁰ Such reassurances can relate the complainant's fears about being 'sectioned' or having their children removed as discussed in Chapter 1.

Meeting needs is in turn dependent on criminal justice personnel being equipped with the skills and understanding to handle cases involving complainants with mental health issues appropriately, and to identify potential support requirements. Also critical is the capacity of the police, CPS and the courts to ensure that appropriate support measures are available when they are likely to be of most material assistance so complainants are not only supported in giving full and reliable evidence in criminal proceedings but also have sufficient trust and confidence to maintain their involvement in an investigation and subsequent prosecution.³⁰¹

Research suggests that complainants may be reluctant to disclose a mental health issue themselves out of embarrassment and fear that it may have an adverse impact on their case by lessening their credibility as a witness. However, this only further reinforces the problem of police identification.³⁰² Nevertheless, research suggests that individual complainants may be more likely to disclose their condition if they are asked about it directly and particularly if it is explained that the information is

³⁰⁰ Ibid 43.

³⁰¹ L Ellison, 'Responding to the needs of victims with psychosocial disabilities: challenges to equality of access to justice' [2015] Crim LR 28, 33.

³⁰² Mind, *Another Assault* (London: Mind, 2007), B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

taken in order to meet their support needs.³⁰³ Ultimately, the appropriateness of asking a direct question regarding mental health is context specific and dependent on the individual. Asking a complainant about her mental health directly, but sensitively and with respect, may help to assist in removing some of the stigma associated with mental health.

In one recent study, police officers described feeling ill-equipped to support victims of crime with mental health problems and indicated that they needed extra support and more comprehensive training in order to undertake this task,³⁰⁴ and foster a better understanding and training regarding mental health.³⁰⁵ But while critics point to the lack of a consistent approach to police training³⁰⁶, complainants' support organisations also report a lack of adequate training. For example, research found that Victim Support, a charity which provides support to victims of crime, have said that they feel they are not properly trained to assist in the area of mental health or feel that they cannot handle it properly. The Witness Service, which can accompany victims in court, also felt inadequately prepared or ill-equipped to assist victims with mental health issues.³⁰⁷ (Although these arguably apply to all victims with mental health issues and not solely to rape complainants.)

³⁰³ R McLeod et al., *Court experiences of adults with mental health conditions, learning disabilities and limited mental capacity Report 2: Before Court Overview and Recommendations* (Ministry of Justice Research Series 9/10, 2010).

³⁰⁴ Ibid

³⁰⁵ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013), R McLeod et al., *Court experiences of adults with mental health conditions, learning disabilities and limited mental capacity Report 2: Before Court Overview and Recommendations* (Ministry of Justice Research Series 9/10, 2010).

³⁰⁶ Ibid.

³⁰⁷ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013) 59.

Part II

The criteria for measuring the quality of a witness's evidence at trial is measured in terms of its likely completeness, coherence and accuracy of testimony.³⁰⁸ It is critical that potential or actual vulnerability is identified at the earliest possible stage; if vulnerability can be missed or not acted upon properly, this can have negative consequences further ahead in the investigation or prosecution of the allegation. For example, the complainant may be overlooked for special measures which can assist how the complainant gives evidence at trial. There is also the risk that the case will be discontinued and no further action taken.

In terms of providing practical or emotional support to complainants with mental health issues, Ellison believes many of the difficulties are due to implementation issues rather than a lack of policy, echoing the views of other critics.³⁰⁹ For example, police and prosecutors are meant to hold an 'early special measures discussion' if it will assist case progression.³¹⁰ Prosecutors should also consider whether it would be beneficial to hold a 'special measures meeting' with a vulnerable or intimidated witness to decide whether an application is appropriate and to discuss the options available.³¹¹ Both of these procedures were enacted in order to promote the effective operation of special measures and to provide a level of reassurance to vulnerable witnesses. However, evidence indicates that they 'rarely take place' in practice.³¹²

³⁰⁸ Section 16(5) YJCEA 1999.

³⁰⁹ K Cook, 'Rape Investigation and Prosecution: Stuck in the Mud?' (2011) 17(3) *Journal of Sexual Aggression* 250; J Brown, 'We mind and we care but have things changed? Assessment of Progress in the Reporting, Investigating and Prosecution of Allegations of Rape' (2011) 17(3) *Journal of Sexual Aggression* 263, *The Stern Review: A Report by Baroness Vivien Stern CBE of an Independent Review into how Rape Complaints are Handled by Public Authorities in England and Wales* (2010).

³¹⁰ Home Office, *Early Special Measures Discussions between the Police and the Crown Prosecution Service* (London: Home Office, 2009).

³¹¹ CPS, *Supporting victims and witnesses with mental health issues* (London: CPS, 2009).

³¹² C Charles, *Special measures for vulnerable and intimidated witnesses: research exploring the decisions and actions taken by prosecutors in a sample of CPS case files* (2012).

While the identification of victims with mental health issues is likely to remain a major difficulty as long as victims have concern about the implications of disclosing their mental health history, it also seems clear that more could be done for the benefit of those who are identified, to increase awareness through training for criminal justice personnel of the specific relevance of special measures to mental health.³¹³

The next part discusses how self- and police-identification of complainants' vulnerability can be improved across the board by giving examples of existing good practice.

The 'vulnerable complainant' – improving police treatment of rape complainants at initial reporting

The police can identify the presence of a potential mental health issue by considering various behaviours, characteristics or circumstances. Some complainants will not want to readily disclose mental ill health but it is a statutory obligation of the police to try to establish any existing issues.³¹⁴ The College of Policing states that police officers should have the training and skills to identify when a person is vulnerable. This does not mean that the police need to be able to diagnose specific illnesses or disabilities, rather that they need to recognise when intervention and support from partner agencies, such as health professionals, may be necessary.³¹⁵ However, identifying a mental health condition or issues is not easy. Although observable behaviour suggesting mental illness may be evident, it should be remembered that odd or erratic behaviour may in fact be attributable to other factors. While there may

³¹³ L Ellison, 'Responding to the needs of victims with psychosocial disabilities: challenges to equality of access to justice' [2015] Crim LR 28, 41.

³¹⁴ Ministry of Justice, *The Code of Practice for Victims of Crime*, para [3.1].

³¹⁵ Home Office, *Supporting vulnerable people who encounter the police: A strategic guide for police forces and their partners* (Home Office October 2014).

be physical or psychological reasons for different sorts of behaviour, ‘it is also possible that this may result from the use of drugs, alcohol, emotional states of frustration, irritability, anger, fear, acute anxiety or a combination of emotions and outside influences.’³¹⁶

As we have seen, vulnerability encompasses various attributes on the part of the complainant. Under the YJCEA 1999, mental health is viewed as a ‘vulnerability’. Section 16 YJCEA 1999 states that vulnerable witnesses are defined as ‘any witness whose quality of evidence is likely to be diminished because they are suffering from a mental disorder.’³¹⁷

Encouraging self-identification

One way to improve confidence in reporting to the police is to encourage effective third party reporting schemes. Tower Hamlets in London has introduced a third party reporting scheme following the Steven Lawrence Inquiry Report, which highlighted the need for independent reporting sites for racially motivated crimes. The scheme now aims to encourage reporting by all victims who may be reluctant to report to the police directly. The third party reporting centres are located in a number of community organisations across the borough. This initiative has also been enacted in Cumbria where there are third party reporting centres, which liaise with police to assist in identifying and investigating crimes against victims with mental health problems. The objectives of third party schemes are to have more complainants with mental health problems reporting crime and to improve links and relationships between police and local services.³¹⁸

³¹⁶ Ministry of Justice, *Vulnerable and Intimidated Witnesses: A Police Service Guide* (2011) [3.2.1].

³¹⁷ As defined by the Mental Health Act 1983 - section 16(5) YJCEA 1999.

³¹⁸ Mind, *Police and Mental Health: How to get it right locally* (ACPO 2013) 14.

Improving identification of vulnerability by police

The following section considers solutions and improvements to identifying mental health issues in complainants. It is critical that police can recognise and assist complainants with mental health problems and that they receive appropriate training in order to do so. It is important to note that the police do not necessarily need to become mental health experts or to address these issues alone; they can work with a wide range of agencies from professional health services to the voluntary sector to ensure an appropriate response meeting the needs of complainants with mental health issues.

Environmental factors, such as homelessness or personal factors such as a medical condition or a combination of the two can give rise to vulnerability. Furthermore, ‘vulnerability may not be constant, consistent or continuous within an individual. Some who would be regarded as vulnerable at the investigation stage might not be at the trial and vice versa.’³¹⁹ Vulnerability may be transient.³²⁰ It can also be the case that the complainant may have an undiagnosed condition.³²¹ A complainant’s vulnerability may be difficult to identify and should be kept under review. Certain frameworks have been developed by the Advocate’s Gateway to assist in identifying vulnerability in complainants of a rape offence. The table below sets out prompts, which may assist the police in identifying a vulnerable complainant and guide decision-making.³²²

³¹⁹ When it comes to later stages of the investigation/prosecution the CPS should not assume that the police have already identified the complainant’s vulnerability.

³²⁰ Ibid.

³²¹ The ATC provide an example: Some disadvantaged people have an attachment disorder, due to erratic parenting and emotional and financial poverty, which then presents as a social communication disorder.

³²² Ibid [3.2.1 – 3.2.4].

Behavioural Prompts	Behaviour Warranting Further Consideration³²³	Circumstances³²⁴
Responds inappropriately or inconsistently to questions, expresses strange ideas	Unusual appearance of the eye	In possession of certain prescription medicine
Appears confused by what is said or happening and does not understand common everyday expressions	Angling head/eyes for viewing	Receiving support from a social worker/community psychiatric nurse
Appears overexcited, exuberant, impulsive OR Appears disinterested, lethargic	Failing to search visually for people i.e. unable to focus or problems with eyesight.	Living in a group or residential home or attending a specialist day service
Appears to have some difficulty understanding questions, or repeats what is said to them	Hesitant in movement or reluctant to move in unfamiliar environment	Receiving support from a carer
Seems to focus on what could be deemed irrelevant small points rather than important issues	Is violent	In receipt of Disability Living Allowance
Is physically withdrawn, inattentive OR Appears very eager to please	Had difficulty knowing the day of the week, where they are and who they are talking to	Is/was under a care order to the local authority (because the complainant may have been taken into care after experiencing trauma)

Table 3: Prompts to Assist in Identification of Vulnerability³²⁵

³²³ i.e. the behaviour may be indicative of a serious mental health issue.

³²⁴ While it is not necessarily proposed that the complainant be questioned on these matters, they are likely to warrant further consideration by the police when present.

³²⁵ Adapted from The Advocate's Gateway, 'General Principles when Questioning Witnesses and Defendants with Mental Disorder: Toolkit 12 (July 2014)

<http://www.theadvocatesgateway.org/images/toolkits/12-general-principles-when-questioning-witnesses-and-defendants-with-mental-disorders-2014.pdf> [accessed Feb 2016].

All the above listed behaviours, characteristics and circumstances are ‘risk factors’ which can indicate potential vulnerability or mental ill health.³²⁶ If missed, behaviour can be misconstrued as being deliberately difficult or unhelpful. The police should therefore be alert to risk factors indicating the complainant is vulnerable and, where identified, appropriate advice, for example medical advice, should be sought.

Certain questions are also good practice in identifying risk factors. For example, asking the complainant: ‘do you need any extra help staying calm?’, and, if it is known that the complainant is taking medication, ‘do you need any extra help taking your medicine?’ or ‘how does your medicine affect you?’³²⁷ Such questions are more likely to elicit useful and reliable information compared to directly asking whether the complainant has a mental health condition due to complainant reluctance to disclose their condition or hesitancy when communicating with police.

Improving police treatment of rape complainants with mental health issues – aids to communication

Research has indicated that the impact of crime can be much greater for complainants with mental health issues. This is because they are more likely to suffer further social, psychological and physical adverse effects as a result of being a victim. As discussed above, a negative encounter or experience with the police can further exacerbate the distress the complainant may be experiencing because of the crime. This may prevent the complainant from going to the police again in the

³²⁶ Advocacy Training Council, ‘Identifying Vulnerability in Witnesses and Defendants: Toolkit 10’ (The Advocate’s Gateway July 2014).

³²⁷ Ibid [1.6].

future.³²⁸ Because victims with mental health issues can have difficulties interacting with the police, there are a number of basic principles which are intended to help police communicate effectively with a complainant with mental health issues and which, if followed, should alleviate distress on the part of the complainant.³²⁹

Statements	Tone and Language	Practicalities	In cases of Hallucinations and Delusions
Present advice to the complainant as a series of options rather than a command	Avoid negative options or language	Explain who you are, what your role is and what the complainant can expect from the police	Remember that these events are real for that person and can be very frightening and distressing for them
Acknowledge how the complainant is feeling, e.g. angry, nervous, but only use statements that are neutral or supportive	Display responsive body language: retain eye contact, nod and use utterances to show understanding	Ask the complainant whether she usually receives support from anyone and whether you can contact that person for them	Do not dismiss, minimise or argue with the person about their hallucinations and delusions
Avoid statements that may appear to belittle someone's feelings (e.g. 'you'll feel better tomorrow', or 'don't worry about it')	Employ a calm and reassuring tone, ask short, simple and open questions	Provide a named officer the complainant can contact and provide regular updates on the investigation and why decisions have been taken	Communicate that you understand and accept that they experience these events but do not pretend that you experience them too
Listen sensitively – allow the		Refer to other services that could	Where possible show that you

³²⁸ Mind, *Police and Mental Health: How to get it right locally* (ACPO 2013) 7.

³²⁹ Ibid.

complainant to talk freely and don't interrupt if they cry or break down, let them express their feelings without rushing		help the person e.g. Victim Support, Independent Sexual Advisors	empathise and understand some of their feelings, e.g. if they are experiencing anxiety
Validate and assure – you can tell them that many people also have similar experiences			Communicate in an uncomplicated and succinct manner, repeating things if necessary. After you communicate something allow plenty of time for the person to process the information and to respond

Table 3.1: Aids to Communication³³⁰

Improving police treatment of rape complainants with mental health issues – good practice in training, education and placements

There are examples of good practice as regards training, education and placements as well as multi-agency collaboration and sharing of information from police forces across England and Wales. These practices have been established to redress some of the problems associated with the treatment of complainants who have a mental health issue.

³³⁰ Ibid 11.

The most critical area is training. This is essential in order for the police to improve their treatment of adults with mental health problems and minimise any deterrent to reporting.³³¹ The Citizens Advice Bureau offers training to its staff on the issue of mental health. The following are key elements for inclusion in training programs: understanding mental health and its effects, including how these might affect a person's cognition and behaviour, and increasing understanding of particular mental health conditions, including how they are experienced. Such training, if implemented, improves the attitudes and behaviours of police officers.³³² This can be seen in the examples of the Essex, Dyfed Powys and Suffolk Police.

Essex Police have developed a one-day mental-health awareness training course that all police officers are required to complete.³³³ The training aims to raise awareness and improve the confidence and expertise of officers when dealing with individuals who may present mental health issues. It provides an overview of the different types of mental health problems; identifies behaviours which might indicate mental health issues and explains how to deal with crisis situations such as suicide or psychotic events. The training provides police officers with the opportunity to reflect on their personal attitudes towards mental health problems and evaluate their professional approach, and confers a better understanding and increased confidence in the area of mental health, as well as practical skills for dealing with people with mental health issues.³³⁴

Dyfed Powys Police and Hywel Dda Health Board collaborate to train police officers in mental health awareness. Student officers complete training delivered by staff at

³³¹ J S Brekke et al., 'Risk for individuals with schizophrenia who are living in the community' (2001) 51 *Psychiatric Services* 1358.

³³² J Livingston et al., 'Perceptions and experiences of people with mental illness regarding their interactions with police (2014) 37 *International Journal of Law and Psychiatry* 334, 338.

³³³ Mind, *Police and Mental Health: How to get it right locally* (ACPO 2013) 16.

³³⁴ *Ibid* 24-5.

the local acute psychiatric ward, followed by a placement within local mental health facilities or at a relevant voluntary sector organisation. This provides officers with the opportunity to interact with services users and gain a better understanding of their experiences and needs. It also encourages closer working relationships with mental health services and community services.

Student officers at Suffolk Police receive training from a forensic psychologist and Registered Intermediary. The training examines how impaired cognitive functioning i.e. impairment of thinking, attention, memory and anxiety, caused by mental health problems can affect a victim's interaction with the police, focusing mainly on police interviews.

Conclusion

There are complexities in defining vulnerability and resolving ways of articulating this to influence police practice. It seems that effectively assessing complainant vulnerability as it relates to mental health at the beginning of the criminal justice process remains problematic, with one of the key problematic areas being the failure to implement existing policy procedures.³³⁵

Cases involving the most vulnerable complainants are least likely to progress through the criminal justice system. For complainants with mental health issues in particular, it can be argued that the 'justice gap' i.e. the rate of attrition, will not be narrowed unless specific attention is devoted to developing investigative and prosecution strategies that specifically address the needs of complainants with

³³⁵ V Stern, *A Report by Baroness Vivien Stern CBE of An Independent Review into How Rape Complaints are Handled by Public Authorities in England and Wales* (London: Home Office 2010).

mental health issues. While complainant vulnerability is identified as an aggravating factor in the SOA 2003, in practice, vulnerability can ultimately undermine complainant credibility.³³⁶ A more victim-orientated approach has been adopted following recommendations from the government listed in Chapter 1. However, more needs to be done to better integrate and improve the relationships between criminal justice agencies and complainants with mental health issues vis à vis interactions with the police. This thesis argues that a key element of such reform is the provision of education and training to police regarding mental health. Training is crucial because it gives police officers the knowledge necessary to recognise, and better understand the needs of complainants with mental health problems and the support they require. A failure to address the particular needs of this vulnerability can affect whether or not the case progresses through the criminal justice system.

I concur with critics that implementation has been failing. To better improve this, there must be a focus on more implementation reviews and more academic evaluation should feed into this process. These suggestions may go some way to overcoming the problems of identification of mental health issues that were discussed in this chapter.

³³⁶ M Hester, *From Report to Court: Rape Cases and the criminal justice system in the North East* (July 2013 University of Bristol and Northern Rock Foundation) 19.

CHAPTER 4: The Police Interview and the Impact of Trauma and Post-Traumatic Stress Disorder on Case Progression – What are the barriers to producing a credible account and the progression of the case to trial?

Introduction

This thesis addresses the ways in which a complainant's mental health influences police and CPS decision-making at different stages of the investigation and prosecution of a rape allegation. This chapter specifically examines the complainant's interview with the police and its perceived impact on case progression and consequent connection with rates of attrition.

This chapter will examine how the mental health conditions of trauma and Post Traumatic Stress Disorder (PTSD) affect the complainant's account given during interview, by examining the symptoms and characteristics of trauma and PTSD and how they affect the complainant's credibility and the quality of account obtained. This ultimately has a bearing on the progression of the allegation and whether the police decide to refer the case to the CPS for charging. The chapter sets out the problem of attrition at this stage in the criminal justice process and known reasons for its occurrence, concluding that the impact of mental health on the attrition rate is not fully understood and more attention should be given to this issue.

I have selected two aspects relating to mental health: trauma and PTSD. The chapter discusses trauma (in the general sense) and PTSD (as a specific mental health

condition recognised in the DSM-V). These two areas of mental health have been selected for two reasons. Firstly, victims of a sexual offence often experience trauma following the rape and this trauma can develop in to PTSD. Secondly, both are closely linked with and affect memory and the complainant's recollection of events is obviously critical to the police interview. Other features of these mental health conditions will also be considered.

The chapter focuses on how the characteristics of trauma and PTSD affect both the type of account the police obtain during interview and how the complainant appears to the police i.e. her demeanour. The chapter analyses the barriers that trauma and PTSD present to the complainant providing and the police eliciting a strong account in interview due to the problems of memory and recall stemming from event. The chapter analyses the influence of these mental health conditions the credibility of the complainant and her allegation, that is, whether the police accept the complainant's account as believable. This assessment in turn affects the decision about whether the case will proceed.

In order to better understand these issues, the following three questions are posed:

- i. How do trauma and PTSD affect the account given during interview?
- ii. In what way are the symptoms of these conditions influential in how the complainant appears to the interviewer?
- iii. What are the factors that lead to and justify non-progression decisions, and what is the role of mental health, specifically trauma and PTSD within these?
How does this ultimately contribute to attrition?

The first question specifically addresses how mental health issues may affect the type of account elicited during interview in terms of its evidential quality, and the

second question focuses on the effect of the complainant's demeanour on the police in terms of assessing credibility. All of these questions bear upon on attrition. We know that attrition rates reflect those cases that are withdrawn or that 'drop out' from the legal process at some stage and do not result in conviction. The third question asks: What factors contribute to the progression (or discontinuance) of rape allegations at this stage? In order to answer this question we consider trauma and PTSD and how their presence is a factor influencing to the decision to continue or drop the case.

The complainant's interview with police is a critical piece of evidence

The stage in the investigation process whereby the police interview the complainant about the allegation of rape to obtain her statement is called an Achieving Best Evidence (ABE) interview. The statement is a narrative account of events according to the complainant and is later deployed at trial as evidence, often becoming the complainant's evidence-in-chief. The quality of the complainant's account is highly influential, if not determinative, as to whether the case for the prosecution proceeds to trial and a conviction for rape is secured.³³⁷

Attrition: Cases drop out at interview stage due to complainant withdrawal or evidential reasons

A key concern of this thesis is the problem of attrition and the view that allegations made by complainants with mental health problems are less likely to proceed to trial.

³³⁷ M Kebbell and N Westera, 'Promoting pre-recorded complainant evidence in rape trials: Psychological practice perspectives' (2011) 35 Crim LJ 376.

Is there a connection between attrition and the complainant's mental health and police investigative factors, that is to say, how the interview with the complainant is conducted? Reasons for attrition are likely to involve a complex interplay of several elements. These are mostly connected to how the police deal with the reported rape, the relationship between the interviewer and interviewee and evidentiary reasons. The quality of the complaints as evidence is crucial.

Once crimes have been recorded by police, for the most part, cases are lost due to either complainant withdrawal or evidential issues. Attrition at an early stage, such as police interviews, is generally due to complainant withdrawal. Attrition at later stages is mostly due to evidential reasons, and as we have seen above, the police interview at this early stage is a crucial piece of evidence.³³⁸ This chapter will examine complainant withdrawal in the context of what transpires during the interview with the police officer. It will then consider evidential reasons in the context of the quality of the account obtained during interview. It will examine how the symptoms of trauma and PTSD are influential upon the quality of the account obtained during interview. How the complainant experiences the interview will be considered first.

The Complainant's experience in interview

The relationship and rapport established between the interviewer and the complainant can affect the level of information disclosed during interview, and therefore this relationship bears scrutiny. Research indicates that a major source of concern for rape complainants with mental health issues is police attitudes of

³³⁸ K Hohl and E Stanko, 'Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales' (2015) 12(3) *European Journal of Criminology* 324.

scepticism and disbelief following a disclosure of rape.³³⁹ Police responses are influenced by judgements regarding the complainant's behaviour or demeanour, which can negatively affect the treatment of that complainant during questioning.³⁴⁰ Complainants' assessments of their experience of the reporting and criminal justice process have been associated with attrition, with recurring associations with credibility and believability.³⁴¹ The HMCPSP and HMIC 2007 review of rape investigation and prosecution in England and Wales highlighted that the attrition rate in was partly linked to 'the behaviour and approach of professionals' and some of the problems in this area included 'insensitive questioning during interviews' and 'judgemental or disbelieving attitudes'.³⁴² A key factor in complainant withdrawal was the perception of police suspicion or scepticism as it led apprehension about the experience of the criminal justice process and the wider consequences of proceeding with the prosecution. This 'culture of suspicion' is one reason given for the low rate of prosecutions by police.³⁴³ As Jordan states, 'victims who declined to complete the initial investigative process and victim withdrawals accounted for over one third of cases lost at the police stage.....key factors in not completing the initial process were being disbelieved and fear of the criminal justice system'.³⁴⁴ This was discussed in Chapter 3 in relation to the initial reporting of the allegation and is also relevant at this stage. Problems arise when the complainant feels that the police do not believe

³³⁹ J Jordan, *Reporting Rape: Women's Experiences with the Police, Doctors and Support Agencies* (Wellington, Institute of Criminology 1998); J Gregory and S Lees, *Policing Sexual Assault* (Routledge 1999), D Lievore, *No Longer Silent: A Study of Women's Help-seeking Decisions and Service Responses to Sexual assault*. A report prepared by the Australian Institute of Criminology for the Australian Government's Office for Women, Canberra 2005).

³⁴⁰ A Dellinger Page, 'Behind the Blue Line: Investigating Police Officers Attitudes toward Rape' (2007) 22 *Journal Police Criminal Psychology* 22.

³⁴¹ J Jordan, 'Worlds Apart? Women, Rape and the Police Reporting Process' (2001) 41(4) *Brit J Criminol* 679.

³⁴² HMCPSP and HMIC, *Without Consent, A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape* (HMCPSP, 2007) 12.

³⁴³ L Kelly et al, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005) 51.

³⁴⁴ *Ibid.*

her account or display an attitude of doubt or disbelief.³⁴⁵ Many rape offences involve persons known to the complainant, either intimately or as an acquaintance. Complainants have reported feeling ‘judged’, especially in situations where the defendant is known to them.³⁴⁶ A study by Patterson examined the relationship between police officers and rape complainants, using the qualitative interviews of 20 adult rape complainants in a Midwest county in the United States. The research found that in instances where a complainant feels judged by the interviewer they were less likely to provide detailed information about the offence.³⁴⁷ If the complainant perceived the interviewer’s demeanour to be cold or felt that the police response to their account was negative in any way they would ‘engage in self-protective behaviour.’³⁴⁸ The result was that the complainant would withhold details if it was thought that this would elicit a negative or hurtful response from the interviewer.

However, detail is critical in adjudication of rape allegations in light of the high number of offences where the complainant and the accused are known to one another.³⁴⁹ Westera, Kebbell and Milne explain how, in the context of consent being the central issue at trial, details will be ‘central to establishing what occurred.’ For

³⁴⁵ J Horney and C Spohn, ‘The Influence of Blame and Believability Factors on the Processing of Simple versus Aggravated Rape Cases’ (1996) 34(2) *Criminology* 135, J Jordan, ‘Worlds Apart? Women, Rape and the Police Reporting Process’ (2001) 41 *Brit J Criminol* 679, L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

³⁴⁶ N Westera, M Kebbell, B Milne, ‘Want a Better Criminal Justice Response to Rape? Improve Police Interviews with Complainants and Suspects’ (2016) 22(14) *Violence against Women* 1748, J Jordan, ‘Worlds apart? Women, rape and the police reporting process’ (2001) 41 *Brit J Criminol* 679-706, L McMillan and M Thomas, ‘Police interviews of rape victims: Tensions and contradictions’ in M Horvath and J Brown (eds.), *Rape: Challenging contemporary thinking* (Willan Publishing 2009) 255-280.

³⁴⁷ D Patterson, ‘The impact of detectives’ manner of questioning on rape victims’ disclosure’ (2011) 17 *Violence Against Women* 1349.

³⁴⁸ D Patterson, ‘The Impact of Detectives’ Manner of Questioning on Rape Victims’ Disclosure’ (2011) 17(1) *Violence Against Women* 1349, 1364.

³⁴⁹ K Daly and B Bourhous, ‘Rape Attrition in the Legal Process: A Comparative Analysis of Five Countries’ (2010) 39 *Crime and Justice* 565.

example, specifics about conversations between the complainant and accused and the ways the complainant may have expressed non-consent are ‘powerful evidential details.’³⁵⁰ If the police are able to elicit more information from the complainant, this produces a more complete account of the rape, and subsequently a stronger case for prosecution.³⁵¹

Research illustrates that if the complainant is fearful of not being believed or senses a prejudicial attitude from the officer, this will affect the quality of the account obtained. Consequently, a comfortable environment is crucial in establishing rapport with the complainant in order to create an environment where the complainant feels listened to and not judged.³⁵² This will assist the complainant in disclosing a more detailed account of events.³⁵³ Any distress felt by the complainant is likely to affect her recall – the more relaxed the complainant, the more likely that she will produce more accurate and specific information.³⁵⁴ However, if the interview experience is an unpleasant one for the complainant, this factor can contribute to the complainant withdrawing the allegation.

Evidential reasons for attrition

Key attrition studies relating to rape and mental health in England and Wales were discussed in Chapter 1, but in the wider context, Daly and Bohours conducted

³⁵⁰ N Westera, M Kebbell, B Milne, ‘Want a Better Criminal Justice Response to Rape? Improve Police Interviews with Complainants and Suspects’ (2016) 22(14) *Violence against Women* 1748, 1750.

³⁵¹ D Patterson, ‘The Impact of Detectives’ Manner of Questioning on Rape Victims’ Disclosure’ (2011) 17(1) *Violence Against Women* 1349, 1366.

³⁵² R Fisher and R Geiselman, *Memory enhancing techniques for investigative interviewing: The cognitive interview* (CC Thomas 1992), R Milne and R Bull, *Investigative interviewing: Psychology and practice* (John Wiley 1999).

³⁵³ M Kebbell and N Westera, ‘Promoting pre-recorded complainant evidence in rape trials: Psychological and practice perspectives’ (2011) 35 *Criminal Law Journal* 376-385.

³⁵⁴ This will be especially difficult for rape complainants experiencing trauma: B van Der Kolk, R Fisler, ‘Dissociation and the fragmentary nature of traumatic memories: Overview and exploratory study’ (2005) 8(4) *Journal of Traumatic Stress* 505.

comparative research of five jurisdictions on the process of attrition in rape.³⁵⁵ The authors found that, on average, only 14% of sexual assaults are reported to police. Of these reports, 30% are referred for prosecution and 15% result in a conviction.³⁵⁶ They further found that the main factors associated with rape cases that did not proceed through prosecution were evidentiary.³⁵⁷ The complainant's police interview is clearly within this sphere because it forms part of her evidence-in-chief. Similarly, in England and Wales it has been suggested that the poor justice outcomes for rape complainants, e.g., the low conviction rate, are partly due to the limitations in the quality, detail and coherence of complainants' statements.³⁵⁸ Although a low conviction rate is one 'poor justice outcome', this can also encompass the police decision to take no further action and discontinue the case. The link between attrition and evidential quality of accounts was noted in Kelly et al.'s research, where the authors conclude that 'evidential issues accounted for over one third of cases lost at the investigative stage...in a substantial number of cases this category the decision not to proceed was linked to victim credibility.'³⁵⁹

The Structure of the ABE interview and guiding documents

'The most powerful evidence in a rape trial is usually the account of the complainant.'³⁶⁰ The complainant is typically the prosecution's main witness and gives her account of what happened. Where the sole issue in dispute is consent, this

³⁵⁵ The jurisdictions were Australia, Canada, England and Wales, Scotland and the United States.

³⁵⁶ K Daly and B Bouhours, 'Rape and Attrition in the Legal Process: A comparative analysis of five countries' (2010) 39 *Crime and Justice* 565.

³⁵⁷ Evidentiary factors included: witness (complainant) testimony and forensic evidence, physical injuries to the victim and use of a weapon.

³⁵⁸ M B Powell and R Wright, 'Professionals' perceptions of electronically recorded interviews with vulnerable witnesses' (2009) 21 *Current Issues in Criminal Justice* 205-218.

³⁵⁹ L Kelly, J Lovett and L Regan *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005) xi.

³⁶⁰ N Westera, M Keibell, B Milne, 'Want a Better Criminal Justice Response to Rape? Improve Police Interviews with Complainants and Suspects' (2016) 22(14) *Violence against Women* 1748, 1757.

testimony forms most of the information upon which the jury will base its decision. The complainant's interview with police is the first stage whereby her full account of events is given; what transpires during interview will shape the account that is obtained, its evidential strength and later assessments of the complainant at trial. This interview, also known as the 'investigative interview', is defined as the obtaining of an account from a victim or witness in connection with an offence.³⁶¹ The aim of the investigative interview is to obtain an accurate and reliable account from the victim, witness or suspect about matters under police investigation.³⁶²

The YJCEA 1999 provides that rape complainants are vulnerable witnesses and are therefore eligible for special measures at trial. This means that the complainant's interview with police may be video-recorded and played to the jury at trial in lieu of live evidence-in-chief. This measure is intended to enable the complainant to give evidence as effectively as possible i.e. her 'best evidence'.³⁶³ Consequently obtaining a strong statement of high evidential quality is likely to improve the chances of conviction, or at least render the account one which a jury will be willing to believe. If a weak account is given during interview, there is increased likelihood of acquittal at trial, so the case may not proceed.

In England and Wales there are two important documents regarding the taking and recording of complainant interviews. The current national guidance for the interviewing of vulnerable and intimidated witnesses is *Achieving Best Evidence in*

³⁶¹ Metropolitan Police Service, Investigative Interviewing Policy (May 2012) <www.met.police.uk/foi/pdfs/policies/investigative_interviewing_policy2012.pdf> accessed February 2015.

³⁶² Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures* (3rd edn, March 2011) <www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf> accessed February 2015.

³⁶³ M Burton, R Evans and A Sanders, *Are special measures for vulnerable and intimidated witnesses working? Evidence from the Criminal Justice Agencies* (Home Office, Jan 2006).

Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures (ABE Guidelines).³⁶⁴ The ABE Guidelines were created in conjunction with the YJCEA 1999. The second relevant document is the National Police Chiefs' Council's *Advice on the Structure of Visually Recorded Witness Interviews* (The NPCC Advice).³⁶⁵ Both documents provide the foundational guidelines for interviewing in this area and their measures are designed to ensure the quality of video-recorded statements.³⁶⁶ In general, the issue of video recording the interview as part of Special Measures will first come to the attention of the police during the investigation. At this stage, a decision will be made as to whether a video-recorded interview should take place.³⁶⁷

The NPCC Advice acknowledges the difficulty inherent to a video-recorded interview, which is that the interview must be structured and conducted in a way that meets the needs of the complainant, the investigation, prosecution, and the overall trial process.³⁶⁸ An oral, 'live', recorded narration presents a challenge to rendering a clear, concise and chronological account of events, as compared with the process of transcribing and producing a written statement.³⁶⁹ An earlier version of the NPCC Advice noted that such difficulties are 'exacerbated when the interview is to be played as the witness's evidence-in-chief and there is no written statement to accompany the recording because the "raw data" of the interview, with all its

³⁶⁴ The Guidelines, currently in their third edition, were revised in 2007 and 2011 in order to take account of the changes to the special measures provisions as result of the Coroners and Justice Act 2009.

³⁶⁵ NPCC, *Advice on the Structure of Visually Recorded Witness Interviews* (2015) [http://library.college.police.uk/docs/appref/NPCC-\(2015\)-Guidance-Visually-Recorded-Interviews%203rd%20Edition.pdf](http://library.college.police.uk/docs/appref/NPCC-(2015)-Guidance-Visually-Recorded-Interviews%203rd%20Edition.pdf)

³⁶⁶ Foreword on page 2 of ABE document.

³⁶⁷ ACPO National Strategic Steering Group for Investigative Interviewing (August 2010) 12. The complainant can elect not to be video-recorded and this may be particularly desired if the offence itself was filmed.

³⁶⁸ ACPO, *The Structure of Visually Recorded Witness Interviews*, ACPO National Strategic Steering Group for Investigative Interviewing (August 2010).

³⁶⁹ College of Policing, *Investigative Interviewing* (2013) <www.app.college.police.uk/app-content/investigations/investigative-interviewing/> [accessed February 2015].

imperfections, becomes the evidential product.’³⁷⁰ An interviewee may recount events in a non-linear, non-chronological order, often switching topic, but this is how individuals recall and recount information to others whether in an interview context or elsewhere. Despite such difficulties, it has been found that playing the video recording of the police interview to the jury is preferable to the complainant giving live evidence-in-chief in the sense that the complainant’s interview with police involves a more complete discussion about legal issues and results in better quality testimony.³⁷¹ Also, the CPS has acknowledged that the video recording enables them to improve case preparation because they can see first hand what the complainant said and how she said it.³⁷²

In terms of structure, the interview consists of four main phases: establishing rapport; initiating and supporting a free narrative account; questioning; and closure.³⁷³ The NPCC Advice adopts the PEACE Framework: Planning and Preparation, Engage and Explain, Account and Clarification, Closure and Evaluation. The ABE Guidelines adopts essentially the same approach and the two documents complement one another. The overarching principle is that commencing the interview with open-ended questions, and allowing the complainant to provide a ‘narrative style’ account, is most likely to elicit the most accurate and detailed version of events.

³⁷⁰ ACPO, *The Structure of Visually Recorded Witness Interviews*, ACPO National Strategic Steering Group for Investigative Interviewing (August 2010) 7.

³⁷¹ N Westera, M Kebbell and B Milne, ‘Losing two thirds of the story: A comparison of the video recorded police interview and live evidence of rape complainants’ [2013] Crim LR 290.

³⁷² Ibid.

³⁷³ Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures* (3rd edn, March 2011). <www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf> [accessed February 2016].

The relationship between rape and mental health

This part examines the relationship between mental health and the effects of being subject to rape. The discussion covers both pre-existing mental health conditions and those which emerge because of the rape.

Studies have shown that some demographic variables such as gender are a factor in the experience of certain mental health issues, because specific disorders are likely to result from certain types of crime. For example, as discussed in Chapter 1, women are more likely to experience rape and domestic or sexual abuse than men.³⁷⁴ Rape and sexual assault and violent crime are more likely to result in post-traumatic stress disorder than other types of crime.³⁷⁵ In this way, certain variables may be a risk factor in ill mental health (in addition to being a risk factor in victimisation).

McNaughton Nicholls conducted a study for the Sentencing Council regarding the impact of crimes on victims. The findings emphasised the long-term physical, psychological and wider impacts of being the victim of a sexual offence:

Post-traumatic stress disorder, depression, anxiety, inability to sleep and other effects such as physical disability....the secondary effect of reducing their ability to work or study, to forge new relationships or maintain positive relationships with family and friends, or their ability to care for others, such as their children. Suicide attempts were also reported.³⁷⁶

³⁷⁴ Access to Justice: *A review of the existing evidence of the experiences of adults with mental health problems* (Ministry of Justice Research Series 06/09, 2009) 6, B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

³⁷⁵ D Kilpatrick and R Acierno, 'Mental health needs of crime victims: Epidemiology and outcomes' (2003) 16(2) *Journal of Traumatic Stress* 119.

³⁷⁶ McNaughton Nicholls et al. *Attitudes to Sentencing: Sexual Offences* (Sentencing Council 2012) 21.

Research has found that complainants with existing mental health issues have reported a significant deterioration in their mental health in the aftermath of an attack, in some instances leading to hospitalisation. In Pettit et al.'s survey of complainants 98% of participants said they had 'emotional or mental health problems' as a result of the victimisation and were more likely to experience social problems such as relationship breakdown or a detrimental effect on employment. Complainants with mental health issues were three times more likely to be 'very much affected' as compared to a sample of victims without mental health issues, even taking the seriousness of the crime into account. The impact of sexual violence was particularly serious, with 40% of women and a quarter of men who were sexually victimised having attempted suicide.³⁷⁷ Based on a review of evidence, female victims of rape and domestic violence were found to be almost four times more likely to have suicidal thoughts compared to non-abused women and up to 50% to have PTSD.³⁷⁸

Having considered how being the victim of a sexual offence can give rise to a mental health issue or worsen a pre-existing mental health condition, the following part introduces the theme of mental health as it relates to the ABE interview.

How can a mental health condition affect the account given during interview?

As the ABE interview will form the foundation of the prosecution's case, it is necessary to examine how a complainant's mental health will affect the interview.

For most complainants, the police interview is a daunting prospect and a source of

³⁷⁷ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

³⁷⁸ M Guggisberg, 'The interconnectedness and causes of female suicidal ideation with domestic violence' (2006) 5(1) Australian e-Journal for the Advancement of Mental Health.

significant anxiety and stress. It is therefore a process that is likely to pose significant challenges for complainants with mental health conditions. These challenges vary in scope and character from one complainant to the other and depend on: the nature and severity of the condition and its associated symptoms; the possible existence of other vulnerabilities, such as alcohol or drug dependency; and the nature of the offence in question.³⁷⁹ For example, according to guidance produced by Mind, some people experiencing mental distress may have difficulty remembering precise dates and times or recalling the peripheral details of an event where a mental health issue affects memory function.³⁸⁰ This is applicable to cases of severe depression or where memory is adversely affected by prescription medication.³⁸¹ Other complainants may have difficulties concentrating for any length of time if they are experiencing obsessive or racing thoughts, which may also affect the ability of some complainants to communicate effectively during interviews.³⁸² It is important that the police make reasonable adjustments – ensuring that breaks are taken would be one way to help the complainant maintain concentration. Complainants suffering from anxiety are susceptible to stress and fear, which act as a barrier to giving an account of what happened. This may revolve around talking about the accused, being in public, or simply having to interact with authority figures such as police officers. A symptom of anxiety disorder is that the individual can experience panic in unfamiliar situations.³⁸³ It is important that the police ensure that interview is conducted in an environment that assists in the complainant's comfort.

³⁷⁹ L Ellison, 'Responding to the needs of victims with psychosocial disabilities: challenges to equality of access to justice' [2015] Crim LR 28, 32.

³⁸⁰ Mind, *Achieving Justice for Victims and Witnesses with Mental Distress: A Mental Health Toolkit for Prosecutors and Advocates* (London: Mind, 2010).

³⁸² Ibid.

³⁸³ Ibid

Mental health conditions can range from generalised anxiety disorder and depression to psychotic conditions like schizophrenia. Each rape allegation involving a complainant suffering from one or more of these disorders is likely to present its own unique challenges in terms of issues relating to a complainant's mental health issue and other associated needs.³⁸⁴ This part will focus specifically on mental health conditions which are directly related to or have a bearing on memory, since memory is a key issue for rape complainants. Providing a coherent, complete and accurate account of the offence is a critical part of a strong interview.

Psychological responses to the trauma of rape can be expressed in the form of feelings of shame, traumatic memories, or dissociation. As discussed in Chapter 2, mental health, like physical illnesses, vary enormously in range. In general, symptoms will fluctuate and individuals with the same diagnosis will experience symptoms in a different way. It is therefore difficult to be overly prescriptive about the potential impact of any mental health condition on a complainant's ability to accurately interpret, recall and relate events and important to note that the context and circumstances will be different for each case. Some complainants may experience effects that interfere with varying degrees with memory, cognitive or communicative function for example, but for others, forms of anxiety disorders such as obsessive-compulsive disorder or social phobia may have no bearing at all on the complainant's reliability as a witness.³⁸⁵ The following section will consider specific mental health issues that can affect the account that a complainant gives during police interview. Details regarding trauma, its effect on memory, and how this in turn affects the conversation with police will now be addressed.

³⁸⁴ L Ellison, V Munro, K Hohl, P Wallang, 'Challenging criminal justice? Psychosocial disability and rape victimisation' (2014) 15(2) *Criminology & Criminal Justice* 225, 239.

³⁸⁵ *Ibid.*

Definition of trauma

Trauma is a common mental health issue for complainants of rape or sexual offences. This part considers how to identify a traumatised complainant and how this will affect the account given in interview. It will consider how the police can work with traumatised complainants and the communication tools that may assist. This topic is examined because the complainant is likely to be traumatised following the attack and this will be a factor that affects the account given in the ABE interview. It is therefore necessary to have early identification of trauma and to ensure that there are proper strategies in place to assist complainants in order to improve the quality of the account obtained.

What is trauma? Trauma is defined as an adaptive response to a threat, one which causes the individual to react 'on the arousal continuum from vigilance through to terror.'³⁸⁶ A traumatic event is a situation in which an individual experiences, witnesses or was confronted with actual or threatened death, serious injury or threat to the physical integrity of others.³⁸⁷ A rape or sexual assault is an example of a traumatic event. Furthermore, traumatic events such as rape can only impair rather than enhance memory performance.³⁸⁸

During the police interview, the complainant provides a free narrative account of the event. The interviewer initiates an uninterrupted account of the incident by means of an open-ended invitation such as 'tell me about what happened'³⁸⁹, and asks the

³⁸⁶ B Perry, 'The Effect of Trauma on Children' (www.childtrauma.org) (2003).

³⁸⁷ American Psychiatric Association, DSM-V (American Psychiatric Association 2013).

³⁸⁸ S Tromp et al., 'Are rape memories different? A comparison of rape, other unpleasant and pleasant memories among employed women' (1995) 8 *Journal of Traumatic Stress* 607.

³⁸⁹ Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures* (3rd edn, March 2011) [3.24] www.cps.gov.uk/publications/docs/best_evidence_in_criminal_proceedings.pdf.

complainant to concentrate on the incident that is the subject of the investigation.³⁹⁰ However, the traumatic nature of rape and the specificity of (often intimate) detail required in order to attain a successful prosecution makes testifying about a sexual assault exceptionally difficult for the complainant.³⁹¹ This is the case even when there is a strong motivation to report the offence and the complainant has a good recollection of events.

When a traumatic event occurs, a physiological response can interfere with information processing. The frontal lobe of the brain, which is responsible for verbal reasoning, organisation and cognitive function, can be significantly altered. The consequence is that traumatic memories are often stored as fragments (behaviour, emotions, sensations and thoughts) that can be reactivated and experienced as if they were happening at that moment. These are known as flashbacks, and can be as distressing as the original event. Physical responses to trauma include startled reactions to minor noise, over-frustration at small irritations and loss of appetite. Sleep can be disturbed (insomnia, nightmares). A traumatic event also interferes with the areas of the brain that interpret experience. This can lead to a sense of anxiety, numbness and shutdown, which can, for example, manifest as ‘confusion, agitation and emotional detachment and sometimes dissociation.’³⁹² If the complainant exhibits signs of agitation this could be interpreted by the interviewer as deceit or an attempt to conceal information. The complainant’s confusion may lead to factual inconsistencies or an incoherent account of the offence. A symptom of dissociation is that the complainant may have significant gaps in her memory. All of these

³⁹⁰ ACPO, *The Structure of Visually Recorded Witness Interviews*, ACPO National Strategic Steering Group for Investigative Interviewing (August 2010) 17.

³⁹¹ A Cossins, ‘Cross Examination in child sexual assault trials: evidentiary safeguard or opportunity to confuse?’ (2009) 33 *Melbourne University Law Review* 68.

³⁹² Advocacy Training Council, ‘Working with Traumatized Witnesses, Defendants and Parties: Toolkit 18 (The Advocate’s Gateway July 2015) [7] citing Perry (2002).

characteristics may negatively affect how the complainant's capacity to deliver a coherent account, and therefore how the police view not just the account but also the complainant herself.

Trauma disrupts the left hemisphere function of the brain, which is the main centre for language and needed for explicit memory or verbal associated memory. The disruption affects the ability to give a verbal narrative – the ability to express oneself. In particular, trauma can affect a person's ability to use language.³⁹³ Regardless of the level of trauma, some people with a history of trauma cannot often put into words their emotions. This will affect the complainant's ability to give details about what she was thinking and felt during the rape.

Trauma affects the ability to understand language, to communicate answers and to think logically. Consequently, trauma can significantly affect a complainant's ability to give an account to the police, her evidence in court or to follow the criminal process. 'For these reasons, attention should be paid to the potential triggers to vulnerability throughout investigation and prosecution.'³⁹⁴ The Advocacy Training Council advises that both police and practitioners 'should have a basic understanding of how trauma affects the brain in order to firstly, facilitate best evidence and secondly, avoid the legal process re-traumatising the complainant.'³⁹⁵

In terms of the police response in this area, the police ought to consider what can be done to reduce the complainant's anxiety and to increase trust in order to enhance participation and improve communication in the interview, thereby improving the quality of the account that is obtained in the investigation. It is important the police

³⁹³ B Van der Kolk, *The Body Keeps the Score: Mind, Brain and Body in the Transformation of Trauma* (Penguin Group 2014).

³⁹⁴ Advocacy Training Council, 'Working with Traumatised Witnesses, Defendants and Parties: Toolkit 18 (The Advocate's Gateway July 2015) [2].

³⁹⁵ *Ibid* [3].

know how to recognise and manage traumatic stress situations and to be mindful that too much information could result in the complainant feeling overwhelmed, which could trigger trauma. It is recommended that the police ensure throughout the interview that the traumatised complainant understands, is given time to consider questions and that the police listen to any suggestions. The complainant needs to feel in control to avoid feelings of powerlessness. The police ought to be particularly alert to complainants who are at a risk of self-harm, attempting or committing suicide.³⁹⁶

It has been noted in Chapter 3 that complainants sometimes have trouble or are reluctant to inform the police of their mental health issues. The Advocate's Gateway has a toolkit to assist in identifying trauma or mental health issues in complainants.³⁹⁷ It includes the following indicators:

- High level of anxiety including panic attacks
- Fixed gaze or smile, may be speechless, mute or frozen
- Malleable/suggestible – appears inattentive
- Unable to absorb, think about or respond to information, questions and comments
- Hyper-vigilant to surroundings and responses of others, startles easily and reacts to sounds, resulting in violent outburst with behavioural and emotional dysregulation and problems modulating impulsivity
- Hypo-vigilant – submissive, may make little or no outward protest concerning what is happening to them and can appear disinterested/lethargic

³⁹⁶ Advocacy Training Council, 'Working with Traumatized Witnesses, Defendants and Parties: Toolkit 18 (The Advocate's Gateway July 2015) [30].

³⁹⁷ Advocacy Training Council, 'Working with Traumatized Witnesses, Defendants and Parties: Toolkit 18 (The Advocate's Gateway July 2015) [30].

- Flat mood: appears disinterested and disconnected.

Further characteristics of trauma mean that the complainant may be difficult to understand, that she may struggle to remain focused or understand questions, or that she focuses on what could be deemed irrelevant, small points, rather than important issues. The complainant may also appear confused by what is said or happening or fail to understand common everyday expressions. Other indicators of trauma include extensive medical history of physical symptoms, a history of depression, anxiety, other mental health conditions, substance misuse, and a history of self-harming.³⁹⁸ However, these matters may not arise during interview.

The impact of trauma on interview: how trauma influences memory

Experiencing a traumatic event such as rape also affects how memory is stored and accessed. There are two forms of memory retrieval: generative and direct. The generative retrieval process is deliberate and is activated when complainants are asked to intentionally activate their memory when reporting details surrounding the rape. Direct retrieval is spontaneous and results in intrusions occurring when the complainant gives an account of the rape to the police. It occurs without any involvement of control processes and instead a cue directly, i.e. spontaneously, 'triggers a stable pattern of activation in the knowledge base which reaches awareness, resulting in an autobiographical memory that has not been intentionally retrieved.'³⁹⁹ This means that there may be no intention to recall the experience but the stimuli present in the interview environment may trigger a sensory or perceptual aspect of the memory which then activates the event and information.

³⁹⁸ J Herman, *Trauma and Recovery: From Domestic Abuse to Political Terror* (Basic Books 1992), Van der Kolk, *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (Guilford Press 1996).

³⁹⁹ A Hardy (2008) 35-6.

It is suggested that generative, i.e. intentional retrieval processes are impaired due to disrupted encoding of information. In contrast, direct or spontaneous retrieval of memories is increased due to enhanced encoding of, and access to, sensory perceptual information. In light of the emphasis placed on the complainant's ability to give a coherent, consistent account of what happened during the rape⁴⁰⁰ disturbances in trauma memory may mean that the complainant will have difficulty with deliberate recall of events whilst simultaneously experiencing involuntary intrusions.⁴⁰¹ In summary, trauma memory is characterised by enhanced direct, i.e. spontaneous retrieval and impaired generative, i.e. intentional retrieval. Direct retrieval seems to occur more often when the complainant is distracted or stressed,⁴⁰² the interview environment being likely to contribute to such feelings because of its intense and pressurised nature. The complainant's ability to recollect the rape is impaired and is potentially a factor which contributes to attrition. This is due to the emphasis which is placed on the complainant's ability to give a coherent and consistent account of the rape. It is easy to see how complainants experiencing such problems with memory may be challenged by the police, as part of their function as investigative officers is to test the complainant's account.

The nature of trauma is such that the memory can become fragmented – the worst moments of trauma can come back as intrusive memories, which are often very clear and vivid. At the same time, other parts of the trauma can be difficult to recall, such as details which were less important to the person at the time (for example, what the person was wearing). It is common for traumatic memories to be jumbled, vague,

⁴⁰⁰ J Gregory and S Lees, 'Attrition in Rape and Sexual Assault Cases' (1996) 36 *Brit J Criminol* 1; Office for Criminal Justice Reform, *Convicting Rapists and Protecting Victims – Justice for Victims of Rape: A consultation Paper* (Home Office, 2006).

⁴⁰¹ A Hardy (2008) 37.

⁴⁰² M A Conway, *Cognitive Models of Memory* (Psychology Press 1997).

have gaps and contain inaccuracies. Traumatic memories are less likely to occur in meaningful order and can be harder to remember when compared with other autobiographical events.⁴⁰³ This is because traumatic memories are encoded by processes (such as repression or dissociation) make them difficult to retrieve as coherent, verbal narratives. This can affect the complainant's ability to recall and articulate the circumstances of the offence. The result is that traumatic memories are primarily available as isolated, nonverbal, sensory and emotional fragments. These memories consist of vividly intense sensory-perceptual impressions that are not placed in context and so are experienced as incoherent and fragmented.

Some people dissociate during a traumatic event, such as rape, which means they spontaneously 'go blank', 'switch off', or 'leave their bodies' (known as an out of body experience) in an attempt to distance themselves from the pain and distress they are feeling.⁴⁰⁴ Consequently, the trauma memory or parts of memory can become inaccessible to conscious awareness.⁴⁰⁵ Memory formation can be disrupted due to the dissociation experienced during trauma. These sensory perceptual changes result in vivid memories that are poorly integrated in autobiographical memory.⁴⁰⁶ The encoding of memory becomes altered, resulting in fragmented yet vivid sensory-perceptual memories or flashbacks being formed.⁴⁰⁷ Individuals who have reported higher levels of peri-traumatic dissociation – 'transient changes in sensory-

⁴⁰³ L Ellison, 'Promoting Effective Case-Building in Rape Cases: A Comparative Perspective' [2007] Crim LR 691, 693.

⁴⁰⁴ E A Holmes et al., 'Are there two qualitatively distinct forms of dissociation? A review and some clinical implications' (2005) 25(1) *Clinical Psychology Review* 1; J Murray et al., 'Dissociation and post-traumatic stress disorder: two prospective studies of road traffic survivors' (2002) 180 *British Journal of Medical Psychiatry* 363; Ozer E J et al., 'Predictors of posttraumatic stress disorder and symptoms in adults: a meta-analysis' (2003) 129(1) *Psychological Bulletin* 52.

⁴⁰⁵ D Wright et al., 'Recovered and False Memories' (2006) 19(6) *The Psychologist* 352.

⁴⁰⁶ C R Brewin and E A Holmes, 'Psychological theories of posttraumatic stress disorder' (2003) 23 *Clinical Psychology Review* 339-376.

⁴⁰⁷ N Grey and E Holmes, "Hotspots" in trauma memories in the treatment of post-traumatic stress disorder: a replication' (2008) 16(7) *Memory* 788.

perceptual experience such as confusion and time distortion’ – during sexual assault perceived their trauma memories to be more fragmented during police interview.⁴⁰⁸

Traumatised complainants can react to stress in ways that can affect the account given to the police initially and then in interview (and later in court).⁴⁰⁹ Memories can return as flashbacks that contain fragments of the experience, isolated images, sounds and body sensations which initially have no context other than fear and panic. People may lose memories only to regain access to them at a later date.⁴¹⁰ This means the complainant could appear contradictory or has a ‘selective memory’, if for example the complainant does not mention something earlier but the recollection comes back later.

Ramifications of trauma-related memory symptoms on the progress of complaints

The evidential strength of the account given during interview is liable to influence how the jury view the complainant’s credibility at trial. Inconsistencies, omissions, or incomplete information can be used by the defence to discredit the complainant at trial. Such inconsistencies or gaps may mean that the police or the CPS assess the complainant’s account as unreliable and therefore determine that there is no realistic prospect of conviction in the first place. Inconsistencies in the account of rape have been found to lead police officers to question the veracity of the complaint and are

⁴⁰⁸ A Hardy, K Young and E A Holmes, ‘Does trauma memory play a role in the experience of reporting sexual assault during police interviews? An exploratory study’ (2009) 17(8) *Memory* 783-788.

⁴⁰⁹ Advocacy Training Council, ‘Working with Traumatized Witnesses, Defendants and Parties: Toolkit 18 (The Advocate’s Gateway July 2015) [5].

⁴¹⁰ *Ibid* [18].

associated with judgements about whether a false allegation has been made.⁴¹¹ The above discussion demonstrates that trauma-related psychological responses may compromise a rape complainant's ability to provide coherent accounts of what happened. This can have a detrimental influence on how the police perceive the complainant, the allegation and therefore the case overall. To provide an illustration of this occurrence, Hester examined attrition in 87 rape cases reported across three police force areas in the north-east of England.⁴¹² Nearly one-in-five victims had a mental health problem according to the police record, and mental health issues were found to be a significant feature in cases that did not result in conviction. Only about a third of cases where the complainant had mental health problems resulted in arrest, compared to half of the cases where no such problems were recorded. In accounting for this high attrition rate, Hester notes that police officers indicated that some complainants with mental health issues were difficult to understand, confused, or in their assessment, delusional. In such instances, the police typically regarded their stories as inconsistent and took the decision not to proceed further with the complaint.⁴¹³ This is also reflected in research by Hardy, Young and Holmes, who found that participants with increased memory fragmentation felt they had provided more incoherent accounts of sexual assault to the police. Increased account incoherence was associated with complaints being less likely to proceed with the allegation.⁴¹⁴

⁴¹¹ J Jordan, 'Beyond Belief? Police, Rape and Women's Credibility' (2004) 4(1) *Criminal Justice* 29; L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

⁴¹² M Hester, *From Report to Court: Rape cases and the Criminal Justice System in the North East* (University of Bristol in Association with the Northern Rock Foundation, 2013). This research was discussed in Chapter 1 as part of 'key studies on attrition'. Here, its relevance pertains to police perceptions of complaints with mental health issues specifically.

⁴¹³ *Ibid*, 13.

⁴¹⁴ A Hardy, K Young and E A Holmes, 'Does trauma memory play a role in the experience of reporting sexual assault during police interviews? An exploratory study' (2009) 17(8) *Memory* 783.

The quality of the account is therefore important since it will impact the jury. If these accounts are not correctly conducted, the case may not be taken forward, or if it is, they may not be believed. However, no empirical research has yet been conducted on the influence, if any, of specific mental health diagnosis on juror decision making. This highlights a gap in the literature and an area for possible area for future research. We do not know how jurors will react, but can still make some inferences. We can draw a parallel by using the findings of rape trial simulations, which suggest that certain case characteristics, including the complainant's consumption of alcohol and evidence of inconsistencies or incomplete recall, can damage credibility in the eyes of mock jurors.⁴¹⁵ For example, credibility is called into question when there are inconsistencies in the account of rape, i.e. incompatible, incoherent and/or illogical details provided by the complainant. Indeed, it has been emphasised that the likelihood of a case being taken forward to court is significantly influenced by the complainant's ability to give a coherent, consistent account of the rape.⁴¹⁶ Therefore, detail, clarity and meaningfulness of reported memories are likely to influence judgements of how 'truthful, accurate, believable and persuasive' they are.⁴¹⁷ This is problematic where complainants report difficulty in giving statements because they are too tired and confused to provide an accurate account, and may not be able to remember prominent details, or where their condition prevents them from doing so.⁴¹⁸ Incoherence and inconsistencies in the complainant's recollection of rape are

⁴¹⁵ E Finch and V Munro, 'The Demon Drink and Demonized Woman: Socio-Sexual Stereotypes and Responsibility Attribution in Rape Trials Involving Intoxicants' (2007) 16 *Social and Legal Studies* 591; L Ellison and V Munro, 'Reacting to Rape: Exploring Mock Jurors' Assessments of Complainant Credibility' (2009) 49(2) *Br J Criminol* (2009) 49 202.

⁴¹⁶ J Gregory and S Lees, 'Attrition in Rape and Sexual Assault Cases' (1996) 36 *Brit J Criminol* 1; Office for Criminal Justice Reform, *Convicting Rapists and Protecting Victims – Justice for Victims of Rape: A consultation Paper* (Home Office, 2006).

⁴¹⁷ D B Pillemer, 'Remembering personal circumstances: A functional analysis' In U Neisser (Ed.) *Affect and Accuracy in Recall: Studies of Flashbulb Memories* (Cambridge UP 1992) 236, 244.

⁴¹⁸ L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

seen as less credible and are more likely to suffer from evidence based attrition.⁴¹⁹

This is because the police, or the CPS, may decide discontinue proceedings because of the quality of the evidence or credibility of the complainant.

Post-Traumatic Stress Disorder (PTSD)⁴²⁰

Trauma concerns the triggering of fear systems which are activated and can continue even when the event has passed. Traumatized people are affected by signals or triggers in their environment, and in certain circumstances extreme trauma can induce a sense of detachment from reality and dissociation as a coping mechanism. As the traumatic event ends, the mind and body slowly move back down the arousal or dissociative continuum. However, if these symptoms persist then the level of trauma may amount to 'post-traumatic stress disorder' (PTSD).⁴²¹ This condition will now be considered.

The psychological consequences of rape are severe and wide ranging.⁴²² Amongst these, rape has been found to be the trauma most commonly associated with PTSD among women⁴²³. Research shows that approximately one third of victims will be diagnosed with PTSD at some time following a sexual assault.⁴²⁴

⁴¹⁹ M Burt M, 'Cultural Myths and Supports to Rape' (1980) 38 *Journal of Personality & Social Psychology* 217; H Gerger et al., 'The Acceptance of Modern Myths about Sexual Aggression (AMMSA) Scale: Development and Validation in German and English' (2007) 33 *Aggressive Behaviour* 422; S *Carnal Knowledge: Rape on Trial* (2nd edn, The Women's Press Ltd 2002); K A Lonsway and L F Fitzgerald, 'Rape Myths: A Review' (1994) 18 *Psychology of Women Quarterly* 133; S Heke and O'Sullivan, 'The Havens and the development of a clinical psychology service in an acute forensic medical service for sexual assault' (2008) *Clinical Psychology Forum* 192.

⁴²⁰ PTSD is a 'trauma and stressor related disorder' according to the DSM-V [309.81].

⁴²¹ Advocacy Training Council, 'Working with Traumatized Witnesses, Defendants and Parties: Toolkit 18 (The Advocate's Gateway July 2015) [4].

⁴²² J Herman, *Trauma and Recovery* (Basic Books 1992).

⁴²³ R C Kessler et al, 'Posttraumatic stress disorder in the National Comorbidity Survey' (1995) 52 *Arch Gen Psychiatry* 1048.

⁴²⁴ A Elklit, D M Christiansen, 'ASD and PTSD in rape victims' (2010) 25 *J Interpers Violence* 1470; S W Masho, G Ahmed, 'Age at sexual assault and posttraumatic stress disorder among women: prevalence, correlates, and implications for prevention' (2007) 16 *J Women's Health* 262; B O Rothbaum et al., 'A Prospective Examination of Post-Traumatic Stress Disorder in Rape Victims' (1992) 5(3) *Journal of Traumatic Stress*; D G Kilpatrick et al., 'Criminal Victimization: Lifetime

PTSD is defined by the DSM-V according to three symptom groups.⁴²⁵ The first is ‘re-experiencing’, which involves recurrent and intrusive thoughts, perceptions, feelings, sensations and dreams relating to the trauma. The second is avoidance and emotional numbing. This entails cognitive or behavioural avoidance of thoughts, feelings, people and places associated with trauma, impaired recall of trauma, and detachment from others and the world. The third group of symptoms is hyperarousal, which can mean difficulty falling or staying asleep, irritability or anger, difficulty concentrating and hypervigilance.

Re-experienced symptoms are considered to be the hallmark of PTSD. They are characterised by intensely vivid, repetitive, threatening sensations and emotions that occurred during trauma, reflecting relatively brief fragments of the event, lasting a few seconds or minutes.⁴²⁶ Behavioural and cognitive avoidance strategies are used in an attempt to cope with distressing intrusions (these are discussed below). However, these paradoxically serve to maintain the intrusive re-experiencing symptoms as they prevent cognitive processing and integration with the complainant’s autobiographical memory. These symptoms draw attention to the paradoxical nature of trauma memory. Individuals may experience intrusive memories whilst at the same time demonstrating impaired intentional recall of trauma.

Prevalence, reporting to police and Psychological Impact’ (1987) 33 *Crime Delinq* 479; S Dahl, Acute response to rape: A PTSD variant (1989) 80 *Acta Psychiatrica Scandinavica* 56-62; R Kessler et al., ‘Post traumatic stress disorder in the National Comorbidity Survey’ (1995) 5(2) *Archives of General Psychiatry* 1060.

⁴²⁵ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders: Fifth Edition – text revision* (DSMV-V-TR) (Washington DC: American Psychiatric Association 2013).

⁴²⁶ A Ehlers and S R Steil, ‘Maintenance of Intrusive Memories in Posttraumatic Stress Disorder: A Cognitive Approach’ (1995) 23 *Behavioural and Cognitive Psychotherapy* 217

The effect of trauma / PTSD on the complainant's account: cognitive avoidance

It is common for a person who has experienced such an event to try not to think about or discuss the trauma and to avoid any thoughts of the event.⁴²⁷ There are problems associated with recounting a traumatic event and it is common for rape complainants to use cognitive avoidance when discussing the event. Cognitive avoidance is a coping strategy whereby a conscious effort is made to avoid thinking about the trauma each time it comes to mind. It is essentially a repression of the memory. There is obvious and understandable embarrassment that the complainant must feel when she is required to recount the graphic details of an intimate sexual offence. The interviewer ought to respond with sensitivity⁴²⁸. A complainant may choose to conceal facts out of 'sheer embarrassment'.⁴²⁹ However, this repression more likely arises from a complex combination of feelings such as humiliation, distress and anxiety, rather than embarrassment alone.

Following a rape the complainant may also experience feelings of shame when she thinks or talks about the event. Feelings of shame are a related feature of PTSD and these have been shown to have a negative effect on both seeking help for and informing another person of the sexual victimisation.⁴³⁰ Such feelings have been linked to 'shame avoidance behaviours' such as lack of eye contact, agitation and avoidance of talking about the event. These same behaviours are associated with

⁴²⁷ The British Psychological Society, *Guidelines on Memory and the Law: Recommendations from the Scientific Study of Human Memory* (June 2008) [5.1] <www.forcescience.org/articles/Memory&TheLaw.pdf>

⁴²⁸ Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings Guidance on interviewing victims and witnesses, and guidance on using special measures* (3rd edn, March 2011) [2.105], [2.213].

⁴²⁹ L Ellison, 'Promoting Effective Case-Building in Rape Cases: A Comparative Perspective' [2007] Crim LR 691, 693.

⁴³⁰ D Bogner et al, 'Impact of Sexual Violence on Disclosure during Home Office Interviews' (2007) 191 *British Journal of Psychiatry* 75.

lying and therefore may influence police perception of the veracity of the complainant.⁴³¹ Feelings of self-blame – commonly associated with shame – are linked to decreased disclosure in victims of acquaintance rape.⁴³² Such feelings may make complainants of rape less certain of their account when disclosing the offence to the police. This, in turn, may affect police perceptions of the reliability of the account, the way that the rest of the interview is conducted, and the manner in which the case progresses.

Taking what we know about a rape complainant's emotional state and the nature of traumatic memory into account, how the complainant appears to the interviewing officer can influence his/her perception of the complainant's credibility and the veracity of her account. Having considered the influence of memory-specific symptoms on the complainant and her account, the next characteristic to examine relates to demeanour.

Numbing

Another normal reaction to trauma is to experience extensive emotional numbing which is another cognitive avoidance technique. This means that the complainant may not appear at all upset when asked about the trauma and will also have difficulty in experiencing and expressing other emotions such as happiness. In particular, numbness or dissociation during an interview makes it less likely for a complainant to show overt signs of distress and therefore less like a stereotypical 'victim' of a sexual assault. This is something that can make the complainant less believable in

⁴³¹ L Akehurst, 'Lay Persons and Police Officers' Beliefs regarding Deceptive Behaviour' (1996) 10 *Applied Cognitive Psychology* 461.

⁴³² M Deitz et al., 'Examining Cultural, Social, and Self-Related Aspects of Stigma in Relation to Sexual Assault and Trauma Symptoms' (2015) 21(5) *Violence against women* 598; L Finkelson and R Oswalt, 'College Date Rape: Incidence and Reporting' (1995) 77 *Psychol Rep* 526.

relation to the allegation.⁴³³ Not only will numbing hinder the experience of providing information to the interviewer; it is also likely to affect how the complainant is perceived by police. Unfortunately, such behaviour may discredit the complainant in the eyes of the police.⁴³⁴ Further, the ABE interview will be played to the jury as the complainant's evidence-in-chief and studies have found that jurors find rape complainants to be less credible if they do not display emotion.

This discussion illustrates how the symptoms of trauma and PTSD can affect the complainant's account during the ABE interview. It can also influence how the police view the complainant. Such factors have a bearing on case progression if the police decide that the case is too weak to continue.

Policy suggestions

The police and the CPS are required to make progression decisions based on the credibility of the complaint, as well as the complainant's ability to withstand giving evidence at trial. However, these assessments may well be complicated by the existence of a history or current diagnosis of a mental health issue, even in circumstances where it remains undisclosed. Indeed, Ellison notes that in a context in which researchers have documented the existence of a substantial over-estimation of the scale of false rape reporting amongst police officers.⁴³⁵ Perhaps a misunderstanding of mental illness may provide an additional reason for such

⁴³³ G Kaufmann et al, 'The Importance of Being Earnest: Displayed Emotions and Witness Credibility' (2003) 17 Applied Cognitive Psychology 21.

⁴³⁴ J Dahl et al., 'Displayed emotion and witness credibility: A comparison of judgments by individuals and mock juries' (2007) 21 Applied Cognitive Psychology 1145, M R Rose, J Nadler and J Clark, 'Appropriately upset? Emotion norms and perceptions of crime victims' (2006) 30 Law and Human Behaviour 203, E Wessel et al., 'Credibility of the emotional witness: A study of ratings by court judges' (2006) 30 Law and Human Behaviour 221.

⁴³⁵ L Kelly, J Lovett and L Regan, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005) page xii, L McMillan L, *Understanding Attrition in Rape Cases* ESRC End of Award Report (2010).

scepticism of the truth of the allegation.⁴³⁶ The more contact police officers have with complainants with mental health issues there will be less adherence to misconceptions about mental health. It is necessary that any police officers or personnel who are likely to interact with complainants be ‘exposed to material that challenges dominant myths and misconceptions in this area.’ There is evidence to suggest that police training is successful in combatting adherence to misconceptions surrounding rape in general and rape complaints with mental health issues in particular.⁴³⁷ Despite progress, a better understanding is still required of the effect of rape upon complainants, particularly in relation to its immediate impact on demeanour and behaviour.⁴³⁸

It is critical that the police, CPS and the courts ensure that appropriate support measures are available when they are likely to be of most material assistance so complainants are supported in giving full and reliable evidence in criminal proceedings. Complainants also need sufficient trust and confidence to maintain their involvement in an investigation and subsequent prosecution.⁴³⁹ Moreover, it is clear that providing appropriate emotional support for complainants will be of paramount importance in many cases given the onerous demands of the adversarial process and the substantial impact that victimisation can have on individuals with mental health issues. For this reason, complainants with mental health issues are seemingly missing out on vital support that could mitigate some of the effects of mental health conditions e.g. problems with recall, communication difficulties and vulnerability to

⁴³⁶ L Ellison, V Munro, K Hohl and P Wallang, ‘Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation’ (2015) 15(2) *Criminology & Criminal Justice* 225, 233.

⁴³⁷ For discussion of success of training of police officers regarding the dynamics of sexual offending see E Darwinkel, M Powell; P Tidmarsh, ‘Improving Police Officers’ Perceptions of Sexual Offending Through Intensive Training’ (2013) 40(8) *Criminal Justice and Behaviour* 895.

⁴³⁸ The Joint CPS and Police Action Plan on Rape (April 2015) contains a list of action points on this issue <www.cps.gov.uk/publications/equality/vaw/rape_action_plan_april_2015.pdf>.

⁴³⁹ L Ellison, ‘Responding to the needs of victims with psychosocial disabilities: challenges to equality of access to justice’ [2015] *Crim LR* 28, 33.

stress – and thereby assist complainants to give their best evidence in pre-trial interviews.

Conclusion

This chapter discussed the problem of attrition in rape allegations and the reasons for non-progression. The evidence indicates that mental health is a factor which influences whether an allegation will proceed. In instances where a complainant has a mental health issue this places barriers to credibility and case progression – the risk of attrition at the interview stage is higher if the complainant suffers from a mental health condition.⁴⁴⁰ The symptoms of a mental health condition such as PTSD or the nature of a traumatic memory can be obstacles to the complainant producing a credible account. The evidential quality of an interview can be influenced by the ability of a traumatised complainant to recall details of the offence – accuracy and consistency may be affected. Furthermore, characteristics displayed in interview may undermine credibility in the eyes of the police: specifically inconsistency and incoherence of account. It further follows that any evidential weakness in an interview account is liable to undermine complainant credibility at trial and ultimately affect the verdict. Inconsistencies or omissions in the account or incomplete information increase opportunities for the defence to discredit the complainant at trial.

Kelly's research suggests that police appraisals of credibility play a key role in attrition. We do know that rates of attrition are higher in cases involving complainants from vulnerable social groups, including people with a mental health condition, and prosecutions are rarely obtained when complainants have mental

⁴⁴⁰ L Ellison, V Munro, K Hohl and P Wallang, 'Challenging Criminal Justice? Psychosocial Disability and Rape Victimisation' (2015) 15(2) *Criminology & Criminal Justice* 225.

health issues.⁴⁴¹ This is particularly concerning given that people with these difficulties have higher rates of rape victimisation compared to persons without mental health issues.⁴⁴² Moreover, evidence indicates that approximately half of people who experience rape will develop mental health issues such as depression and PTSD.⁴⁴³ This chapter sets out the problem of attrition at this stage in the criminal justice process and known reasons for its occurrence, concluding that the impact of mental health on the attrition rate is not fully understood and more attention should be given to this issue.

⁴⁴¹ See discussion of this issue in Chapter 1 and studies by Grace et al. 1992, J Harris and S Grace, *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s*, Home Office Research Study 196 (HMSO: London 1999); J Gregory and Lees, *Policing Sexual Assault* (Routledge 1999), Gregory J and Lees S, 'Attrition in Rape and Sexual Assault Cases' (1996) 36 *Brit J Criminol* 1; S Lea et al, 'Attrition of Rape Cases: Developing a Profile and Identifying Relevant Factors' (2003) 43(3) *Brit J Criminol* 583; Kelly, Lovett and Regan *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

⁴⁴² K T Mueser et al., 'Trauma and posttraumatic stress disorder in severe mental illness' (1998) 66 *Journal of Consulting and Clinical Psychology* 493.

⁴⁴³ R Kessler et al., 'Posttraumatic stress disorder in the National Comorbidity Survey' (1995) 5(2) *Archives of General Psychiatry* 1060.

CHAPTER 5: Pre-Trial Disclosure of Material

Relating to the Complainant's Mental Health

Introduction

The previous chapter examined the complainant's interview with the police. It explored how being traumatised or suffering from PTSD is a factor that can affect the account given to the police and how the complainant appears to the interviewer. This chapter focuses on the next phase of the process, specifically pre-trial disclosure. This is the point at which the allegation has been referred to the CPS for charge and the CPS has elected to prosecute. In essence, full disclosure should be made of all material held by the prosecution that weakens its case or strengthens that of the defence. Disclosure is designed to ensure that the prosecution provide the defence with 'relevant material' and is intended to make certain that information that is of genuine relevance to the case is available to all parties and to the court.⁴⁴⁴ This chapter focuses on the problems associated with the disclosure process as it pertains to rape complainants with mental health issues.

Three significant concerns are explored in this chapter. Firstly, there is some evidence of a trend of 'blanket disclosure' whereby the prosecution adopt an approach in which the material or documents concerning the complainant are disclosed as a matter of course, even where they are not required to be disclosed under the Criminal Procedure and Investigations Act 1996. Such material can be confidential in nature and is a breach of the complainant's right to privacy. Medical records of a complainant are confidential between the medical practitioner and the

⁴⁴⁴ Attorney General's Guidelines on Disclosure 2013 (AGs Guidelines), CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance' para [3.9] <www.cps.gov.uk/publications/prosecution/pretrialadult.html> accessed July 2016.

patient and the patient has a right of privacy under Article 8 of the European Convention on Human Rights (ECHR).

The second concern involves the prosecution's failure to obtain the complainant's consent to disclosure and the fact that this is also in breach of the complainant's right to privacy. The third and related issue is that a refusal on the complainant's part to allow the defence access to this material is likely to result in a discontinued prosecution. This is because any conflict between the accused's right to a fair trial and the complainant's right to privacy is likely to be resolved by the court in favour of the defendant.

The examination of a pre-trial process highlights how a CPS decision to discontinue the case, thereby affecting upon attrition rates, relates to the complainant's mental health. Therefore, the present chapter examines the rules and procedures that govern disclosure during a rape prosecution. Based on this discussion, the next chapter expands upon more in detail on how, when the defence have access to this material, this is a factor unfairly influencing the assessment of the complainant. The material relating to the complainant's mental health that is adduced at trial has a bearing on how the jury view the complainant and her account and Chapter 6 examines how damaging the content can be. If the evidence undermines credibility this may be a factor leading to an acquittal of the defendant, and this is the final attrition point in the criminal justice process.

Before considering these issues in closer detail, the following section will examine the basis and history of disclosure, the applicable procedure and relevant tests applied.⁴⁴⁵

A brief introduction to disclosure

The origins of the disclosure regime trace back to The Royal Commission on Criminal Justice (the Runciman Commission) which was established to investigate, *inter alia*, a series of false convictions in 1970s and 1980s.⁴⁴⁶ These false convictions had been obtained partly due to the prosecution's failure to make proper disclosure to the defence. Following the Runciman Commission, new rules governing disclosure were introduced and set out in the CPIA 1996.⁴⁴⁷

The Crown's duty of disclosure is a central aspect of adversarial trial process and shares a close relationship with both fair trial and equality of arms principles.⁴⁴⁸ The right to a fair trial is embodied in Article 6 ECHR. Disclosure of material to the accused is a crucial element of this right.⁴⁴⁹ The basis of the equality of arms

⁴⁴⁵ For general discussion on disclosure see: J Niblett, *Disclosure in Criminal Proceedings* (Blackstone 1997); R Percival and D Ormerod, 'Disclosure' [1998] Crim LR 58; J Sprack, 'The Duty of Disclosure' [1997] Crim LR; R Leng, 'The Exchange of Information and Disclosure' in M McConville and G Wilson (eds), *The Handbook of the Criminal Justice Process* (OUP, 2002); D Ormerod 'Improving the Disclosure Regime' (2003) 7 E & P 102; M Redmayne, 'Criminal Justice Act 2003 (1): Disclosure and its Discontents' [2004] Crim LR 441; H Quirk, 'The Significance of Culture in Criminal Procedure Reform: Why the Revised Disclosure Scheme Cannot Work' (2006) 10 E & P 42; C Taylor, 'Third Party Disclosure' (2006) 70(5) Journal of Criminal Law; D Ormerod, A Further Review of Disclosure [2013] Crim LR 97.

⁴⁴⁶ Such as the Birmingham Six; Guildford Four; Maguire Seven and Judith Ward. *R v McIlkenny* [1992] 2 All ER 417; (1991) 93 Cr App R 287; *R v Ward* [1993] 2 All ER 577; (1993) 96 Cr App R 1; *R v Maguire* [1992] QB 936; (1992) 94 Cr App R 133; *R v Richardson*; *R v Conlon*; *R v Armstrong*; *R v Hill* Court of Appeal (Criminal Division) 19 October 1989; *The Times*, (20 October 1989).

⁴⁴⁷ The Royal Commission on Criminal Justice (Runciman Commission) (Cm2263, 1991); J Sprack, 'The Criminal Procedure and Investigations Act 1996: (1) the Duty of Disclosure' [1997] Crim LR 308; J Glynn, 'The Royal Commission on Criminal Justice: Part 4: Disclosure' [1993] Crim LR 841; S Field and J Young, 'Disclosure, Appeals and Procedural Traditions: *Edwards v UK*' [1994] Crim LR 264.

⁴⁴⁸ The Crown and the CPS are terms used interchangeably but the meaning is the same.

⁴⁴⁹ Attorney General's Guidelines on Disclosure 2013 at [2]; S Sharpe, 'The Human Rights Act 1998: Part 3: Article 6 and the disclosure of evidence in criminal trials' [1999] Crim LR 273. See generally

principle is that due to the State's greater financial and investigative powers, the defence is entitled to have access to the same material that is available to the State.⁴⁵⁰ The defence has a right to examine all information uncovered in the course of a criminal investigation that might mitigate the accused's liability or undermine the prosecution case.⁴⁵¹ However, the judgement about what sort of material is 'capable of undermining the prosecution' case in the context of a rape complainant with a mental health issue can be problematic. This is because in the context of allegations of a sexual nature, the material may be critical to the defence if the case is one in which there is no evidence of the offence itself other than one person's words against another's. This means that the court's monitoring of disclosure is an important safeguard against the possibility of a miscarriage of justice and procedural fairness to both the complainant and the accused, as it means that both parties have access to the same information.⁴⁵² Yet, in such circumstances, the nature of what 'material' is capable of undermining the case may be wrongly expanded to include evidence of the complainant's mental health.

It does not matter that the prosecution does not intend to rely on the material at trial as it may be of value to the defence. Disclosure is one of the most important procedures to take place in a criminal trial and it is essential that both sides discharge

R Goss, *Criminal Fair Trial Rights: Article 6 of the European Convention on Human Rights* (Hart Publishing, 2014).

⁴⁵⁰ *Salov v Ukraine* (app.no.65518/01), ECtHR Judgement 6 September 2005 at [87]: '[T]he principle of equality of arms is only one feature of the wider concept of a fair trial, which also includes the fundamental right that proceedings should be adversarial....Furthermore, the principle of equality of arms – in the sense of a "fair balance" between the parties – requires that each party should be afforded a reasonable opportunity to present his case under conditions that do not place him at a substantial disadvantage vis-à-vis his opponent...the right to adversarial proceedings means that each party must be given the opportunity to have knowledge of and comment on the observations filed or evidence adduced by the other party...'

⁴⁵¹ Judiciary of England and Wales, 'Judicial Protocol on the disclosure of unused material in criminal cases' (December 2013).

⁴⁵² J Rook and R Ward, *Rook and Ward on Sexual Offences: Law and Practice* (4th edn, Sweet & Maxwell 2010) para [25.03 - 04]. The court monitors the disclosure process through pre-trial hearings as the issue of disclosure will arise at the Plea and Trial Preparation Hearing (PTPH).

disclosure obligations.⁴⁵³ If prosecutors do not consider whether material is disclosable under the CPIA 1996, they risk failing to identify and therefore disclose material which should be given to the other side. The consequences of such failure include the accused may raise a successful abuse of process argument at trial, the accused may be released from the duty to make defence disclosure, costs may be awarded against the prosecution, or the court may decide to exclude evidence because of the breach of the CPIA 1996.

It is obvious that the pre-trial process of disclosure is an important aspect of criminal proceedings. A ‘disclosure regime’ or framework exists in England and Wales which consists of the CPIA 1996, the Code of Practice, the 2013 ‘Judicial protocol on the disclosure of unused material in criminal cases’ (the Disclosure Protocol), and Attorney General’s Guidelines on Disclosure (AG Guidelines). The obligations of disclosure placed on the prosecution are set out in the Criminal Procedure and Investigations Act 1996 (CPIA 1996). Section 3 of the CPIA 1996 reads as follows:

3 Initial duty of prosecutor to disclose

(1) The prosecutor must—

(a) disclose to the accused any prosecution material which has not previously been disclosed to the accused and which might reasonably be considered capable of undermining the case for the prosecution against the accused or of assisting the case for the accused, or

(b) give to the accused a written statement that there is no material of a description mentioned in paragraph (a).

⁴⁵³ M Blake and A Ashworth, ‘Some Ethical Issues in Prosecuting and Defending Criminal Cases’ [1998] Crim LR 16; C Humphreys, ‘The Duties of Prosecuting Counsel’ [1955] Crim LR 739.

Such information or ‘material’ as referred to in section 3 is defined as ‘unused material’ that may be relevant to the investigation that has been retained but does not form part of the case for the prosecution against the accused.⁴⁵⁴ ‘Relevant material’ is defined, in prosecutorial guidelines, as information which may prove, or disprove, the issues disputed by the prosecution and defence. The CPS is under an obligation to reveal material to the defence which would undermine the prosecution case or assist that of the accused.⁴⁵⁵ This is known as ‘the disclosure test.’

The courts have drawn a clear distinction between documents in possession of the prosecution, where there is a strict duty of disclosure on the prosecutor, and those in possession of a third party, where there is no duty of disclosure on the third party.⁴⁵⁶

It is material which is in the possession of third parties that typically presents the most issues in this area of pre-trial procedure.⁴⁵⁷ This is because documents that are likely to be relevant at trial tend not to be voluntarily disclosed by third parties and they are under no voluntary duty of disclosure. The prosecution may struggle to gain access to the information where the third party is reluctant to disclose the material. In addition, the complainant has a (reasonable) expectation that the material containing personal information would remain confidential, and may therefore oppose disclosure, particularly in cases where the material concerns the complainant’s mental health or medical history. This is discussed later in the chapter.

⁴⁵⁴ CPS ‘Disclosure Manual’ para [1.6].

⁴⁵⁵ Section 3 CPIA 1996. The disclosure framework consists of the CPIA 1996, the Code of Practice, the Judicial protocol on the disclosure of unused material in criminal cases and the AG Guidelines.

⁴⁵⁶ R v Derby Magistrates’ Court ex parte B [1995] 4 All ER 526.

⁴⁵⁷ Other material such as telephone records, social media communications between the complainant and accused and CCTV footage are all classifiable as third party material. Such forms of information are not examined as part of this thesis.

The mechanics of disclosure regarding rape prosecutions

The range of material subject to disclosure rules is very broad, including medical records or counselling records after the offence occurred or other documents relating to the complainant's mental health.⁴⁵⁸ Continuing the approach taken in previous chapters, mental health relates to both complainants with pre-existing mental health conditions and those who seek counselling or therapy following a rape.

In the context of a rape investigation, any material and reports which are related directly to the assault, such as medical reports and statements made to the police, are relevant. As discussed in Chapter 3, following the initial reporting of the allegation to the police the complainant attends an SARC where a forensic medical examination is conducted. This requires the consent of the complainant, and in consenting to the examination the complainant is also consenting to the results of the examination, i.e. the medical report relating to the allegation, being used as evidence.⁴⁵⁹ The medical report that contains the results from the forensic medical examination will be given to the defence. However, there is other information included in documents such as psychiatric reports and counselling records that may possess less (obvious) relevance to the prosecution. The information may already be in the possession of the prosecution, or it may be in the hands of a third party such as a counsellor, NHS Trusts, social services, the medical profession or the SARC or similar victim support service. Different rules and principles apply to material which is held by the prosecution as compared with that which is in the possession of a third party. Material in possession of the prosecution will be addressed first.

⁴⁵⁸ The admission of counselling records at trial is the subject of the next chapter.

⁴⁵⁹ 'From Report to Court: A Handbook for Survivors of Sexual Violence' (Rights of Women 2014) 36. <<http://rightsofwomen.org.uk/wp-content/uploads/2014/10/PDF-of-From-Report-to-Court-a-handbook-for-adult-survivors-of-sexual-violence.pdf>> accessed July 2015.

Prosecution duty to disclose – Criminal Procedure and Investigations Act 1996: prosecution in possession of material

In making disclosure decisions, the prosecutor must have regard to the Disclosure Protocol and the AG Guidelines. While the AG Guidelines do not have the force of law, the prosecutor is required to give them ‘due weight’ in decision-making.⁴⁶⁰ This means that if the prosecution fails to comply with its obligations under the disclosure regime, this can constitute the basis of an appeal against conviction.⁴⁶¹ For ease of reference, the test for disclosure of material in possession of the prosecution is set out in section 3 of CPIA 1996 and states:

[t]he prosecution must provide the defence ‘with copies of, or access to, any prosecution material which might reasonably be considered capable of undermining the case for the prosecution against the accused, or of assisting the case for the accused, and which has not previously been disclosed.’⁴⁶²

In considering how the material is capable of undermining the prosecution case or of assisting the defence, the prosecution must have regard to the following non-exhaustive list of factors:

- the use that might be made of the material during cross-examination,
- its capacity to suggest an explanation, or,
- partial explanation of the accused’s actions.⁴⁶³

⁴⁶⁰ AG’s Guidelines, para [13].

⁴⁶¹ The law is set out in the CPIA 1996 as amended by the CJA 2003 and applies to all cases where the investigation commenced on or after 4 April 2005.

⁴⁶² s3(1)(a) as amended by s32 CJA 2003. This is also known as ‘the disclosure test’.

⁴⁶³ AG’s Guidelines, para [6]. It is worth noting that this test does not include an assessment as to whether the material is or could be admissible in a trial.

The prosecution's duty to disclose materials requires the prosecution to anticipate what material might undermine its case or strengthen the defence case, having taken into account information revealed as part of police investigation or during questioning. The duty of disclosure is a continuing one and material may need to be disclosed as the case progresses.⁴⁶⁴ This is because the potentially relevant material might undermine the prosecution or assist the defence at different stages of the trial process. New relevant material may emerge through the trial and the prosecution is obliged to disclose this to the defence. The prosecution must evaluate all materials using the disclosure test. By way of illustration of the continuing duty of review – if complainant informs the prosecutor at a later stage that she has been receiving counselling following the rape, the defence needs to be informed of this fact.⁴⁶⁵ Nonetheless, prosecutors need to consider very carefully if medical records or counselling notes are disclosable to the defence, and if so, whether this applies to all of the material or only part of it. For example, in the case of medical records, it is likely that some entries will be of a routine medical nature and will not fall to be disclosed under the CPIA 1996. In such circumstances, it is possible to 'redact' the material and only disclose that part which is relevant.⁴⁶⁶

The next section looks at how the disclosure test applies to material in the hands of third parties. This is a more problematic area. Material in possession of third parties that relates to the complainant's mental health further complicates issues of obligatory disclosure, the complainant's right to privacy and the defendant's right to a fair trial. Problems arise in regards to blanket disclosure and incorrect application of the CPIA 1996, and the complainant's privacy and the failure to obtain consent.

⁴⁶⁴ *ibid* [5].

⁴⁶⁵ This example is considered in detail in the next chapter.

⁴⁶⁶ HMCPSI, *Disclosure of Medical Records and Counselling Notes* (July 2013) para 2.2.

The following section examines these concerns in light of the rules governing third party disclosure.

Rape prosecutions: material in the hands of third parties

During a rape investigation, the prosecution will likely be dealing with third parties such as medical practitioners, counsellors and therapists, hospitals, social services departments, and schools.⁴⁶⁷ The prosecution is under an obligation to actively seek out relevant material that is possession of third parties which they know to exist and is likely to satisfy the disclosure test.

There are different types of material that may satisfy the disclosure test and therefore require consideration by the Crown. CPS policy provides that:

If the material is not already in possession of the prosecution (as a result of police investigative process) then the material is typically in the hands of third parties such as doctors; psychologists or counsellors. The prosecution have an obligation to locate the information and disclose it to the defence if it is “unused material” and likely to undermine the prosecution case or assist the defence.⁴⁶⁸

The prosecution must seek to recover any material which is relevant to the credibility or reliability of the complainant’s account. The information may be contained within documents such as records, notes or correspondence concerning the complainant. Doctors (medical or psychiatric records), psychologists or counsellors (therapy notes), social workers (Local Authority material) or teachers (educational records)

⁴⁶⁷ Third party material is material held by a person, organisation, or government department other than the investigator and prosecutor within or outside the U.K.

⁴⁶⁸ CPS, ‘Disclosure Manual’, <www.cps.gov.uk/legal/d_to_g/disclosure_manual/> accessed July 2016.

will have prepared these documents.⁴⁶⁹ The more vulnerable the complainant, the more likely it is that social services or other authorities possess files about the complainant's condition.⁴⁷⁰ This is particularly true where the complainant has a mental health issue or has some form of learning disability.⁴⁷¹ Rape complainants who have been subject to more than one sexual offence are also likely to be heavily documented, with records regarding previous victimisation being kept by police, doctors, and counsellors.⁴⁷²

The *AG Guidelines* require the prosecutor to take reasonable steps 'to identify, secure and consider material held by any third party where it appears ... (a) that such material exists and (b) that it may be relevant to an issue in the case'. How do the CPS know that this material exists? The Protocol between the Police Service and the CPS in the Investigation and Prosecution of Rape⁴⁷³ specifically states that the police will have medical records and counselling notes as part of its investigation into the case. This forms part of the material the police hand over to the CPS. Furthermore, CPS prosecutorial guidance makes reference to this material as part of its 'Rape Prosecutions Advice/Review Checklist'.⁴⁷⁴ This means the CPS are aware and know

⁴⁶⁹ Another category of third party material is telephone evidence e.g. content of text messages between complainant and accused. This is in addition to social media material such as Facebook posts e.g. *R v T* [2012] EWCA Crim 2358. In this case the complainant posted messages on the accused's wall and sent photographs of herself.

⁴⁷⁰ Vulnerable adults being defined in s16 YJCEA 1999 – witnesses eligible for assistance on grounds of age or incapacity and s17 YJCEA 1999 – witnesses eligible for assistance on grounds of fear or distress about testifying. Complainants in sexual offences are automatically eligible for assistance by virtue of s17(4).

⁴⁷¹ Rook and Ward, *Rook and Ward on Sexual Offences: Law and Practice* (4th edn, Sweet & Maxwell 2010) para [25.32].

⁴⁷² J Benedet and I Grant, 'Hearing the Sexual Assault Complaints of Women with Mental Disabilities: Evidentiary and Procedural Issues' (2007) 52 McGill Law Journal 515, 542. The third party material can cover Social Services, Educational, Medical, Therapy, Counselling, Adult and Child Disability Services, Care Proceedings / family / disciplinary proceedings, SARC records and Independent Sexual Violence Advisor Records.

⁴⁷³ ACPO and CPS, Protocol between the Police Service and the Crown Prosecution Service in the Investigation and Prosecution of Rape (June 2015)

https://www.cps.gov.uk/publications/agencies/cps_acpo_rape_protocol_v2-1.pdf

⁴⁷⁴ CPS, 'Rape and Sexual Offences: Chapter 15: Disclosure and Third Party Material' and Rape and Sexual Offences: Appendix D – Rape Prosecutions Advice/Review Checklist.

to look out for this information in both instances. If the CPS know that the material or records exist and are potentially relevant and have not already been disclosed by the police as part of the investigation, they must seek to access them.

What kinds of enquiries must the prosecution make in order to discharge its disclosure obligations? CPS guidance provides that a fair investigation requires the prosecution to pursue all reasonable lines of enquiry as to the existence of any relevant material in the possession of a third party.⁴⁷⁵ The CPIA 1996 and its accompanying Code of Practice impose an obligation on the prosecution to pursue all reasonable lines of enquiry, whether these inculcate or exonerate the accused. Firstly, what are the criteria for determining that the material is relevant and whether any attempt should be made to obtain it? Secondly, what is the extent of the prosecution's duty to secure material held by third parties?

What constitutes 'reasonable steps' will depend on the context and nature of the case. Before taking steps to obtain third party material, it must be shown there was not only a suspicion or supposition that the third party possesses the relevant material, but also an expectation that the material was likely to satisfy the disclosure test.⁴⁷⁶ Should this be the case, prosecutors should take reasonable steps to ensure the disclosure of documents held by third parties. Reasonable steps may include telephone calls, emails or written legal requests for disclosure. Material in the possession of a third party is not disclosable simply because it, or might be, relevant to an issue in the case. Before it can be said that there has been a breach of an obligation under the AG Guidelines, it must be shown that there is suspicion that the third parties not only had potentially relevant material, but that the material was not

⁴⁷⁵ CPS, 'Rape and Sexual Offences – Chapter 15: Disclosure and Third Party Material. <www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/disclosure_and_third_party_material/> accessed July 2016.

⁴⁷⁶ R v Alibhai [2004] EWCA Crim 681, CA.

solely neutral or damaging to the defendants, but damaging to the prosecution or of assistance to the defendants.⁴⁷⁷

As part of the prosecution the CPS will have a disclosure officer who is in charge of the investigation but who is not required to make speculative enquiries. There must be some reason to believe that the third party may have relevant material.⁴⁷⁸ The prosecution has a ‘margin of consideration’ as to what steps to take in the case and is not under an absolute obligation to obtain material that is suspected to satisfy the disclosure test. This means that the decision is discretionary, the prosecution having the power to decide what steps are appropriate in the circumstances of each individual case. This approach is supported by the AG Guidelines, which provide that a fair investigation does not mean an endless investigation.⁴⁷⁹

Evidence of a trend?

There is a current gap in the field regarding the number and frequency of disclosure applications made in England and Wales concerning material relating to the complainant’s mental health. Kelly, Temkin and Griffiths conducted research for the Home Office which investigated the extent to which applications for disclosure of confidential records were made in sexual assault cases.⁴⁸⁰ Their research found that 71 applications were made out of a case sample of 236.⁴⁸¹ These requests occurred across 54 separate cases, which is nearly one quarter of the total sample. A point of interest regarding the connection between these applications and attrition can be noted. Although the study did not monitor whether or not the applications were

⁴⁷⁷ R v Alibahi Arch. News 2004, 5, 1-2

⁴⁷⁸ Rook and Ward, *Rook and Ward on Sexual Offences: Law and Practice* (4th edn, Sweet & Maxwell 2010) para [25.17].

⁴⁷⁹ AG’s Guidelines para [17].

⁴⁸⁰ L Kelly, J Temkin and S Griffiths, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* (Home Office Online Report 20/06, 2006).

⁴⁸¹ *Ibid* 25.

successful, where an application was made, 55 % resulted in acquittal, whereas in cases where no application was made 47 % of those cases resulted in acquittal.⁴⁸²

HMCPsi review of CPS compliance with proper disclosure of complainant's medical records and counselling notes

Disclosure problems in practice

However, in practice it appears there are significant issues with how the disclosure system operates in England and Wales. Notably, in regards to the CPS failing to consider disclosure properly or 'over-disclosing' material and failing to consider and/or ensure that consent from the complainant to allow access to the material been obtained. These concerns were verified in 2013, as part of its Annual Casework Examination Programme, inspectors from Her Majesty's Crown Prosecution Service Inspectorate (HMCPsi) examined 58 cases, from ten CPS areas, which involved allegations of rape or a sexual offence where the unused material included complainant's medical records and/or counselling notes.⁴⁸³ The review investigated three significant issues regarding general compliance with disclosure obligations and obtaining the complainant's consent to disclosure. The review found that prosecutors:

- Do not always consider properly whether or not there is a need to disclose everything in a medical record or in counselling notes

⁴⁸² Ibid 28.

⁴⁸³ HMCPsi, *Disclosure of medical records and counselling notes : a review of CPS compliance with rules and guidance in relation to disclosure of complainant's medical records and counselling notes in rape and sexual offence cases* (July 2013) http://www.justiceinspectors.gov.uk/crown-prosecution-service/wp-content/uploads/sites/3/2014/04/DOMRACN_thm_Jul13_rpt.pdf [accessed July 2016].

- Do not actively consider whether or not a complainant's consent has been obtained to disclose medical records and/or counselling notes to the defence
- Can find it difficult to ascertain whether the police have properly obtained the complainant's consent to disclosure of medical records and/or counselling notes.⁴⁸⁴

The review specifically asked whether the complainant records were disclosable under the CPIA 1996. The HMCPSI found that prosecutors generally considered medical records and counselling notes to ascertain whether they were disclosable, and did so in 82 % of the file sample. Where medical records and counselling notes should have been disclosed under the CPIA 1996, in 86.5 % of the relevant cases they were so disclosed. However, in four of 50 relevant cases (8 %), the prosecution failed to consider disclosure.

The review also looked into the continuing obligation to disclose. One of the key issues discussed in the review is that where new material comes to light, which substantially undermines the prosecution case, assists the defence, or raises fundamental questions about the prosecution, prosecutors may need to reassess the case in accordance with the *Code for Crown Prosecutors* and decide whether the case should continue.⁴⁸⁵ The HMCPSI examined whether the material in each case which was not disclosed which should have been and it would have impacted on the question of whether there was a realistic prospect of conviction. The 'realistic prospect of conviction' is part of the first stage in the CPS' decision to prosecute, but

⁴⁸⁴ HMCPSI, 'Disclosure of medical records and counselling notes: a review of CPS compliance with rules and guidance in relation to disclosure of complainant's medical records and counselling notes in rape and sexual offence cases' (News release, July 2013) http://www.justiceinspectors.gov.uk/crown-prosecution-service/wp-content/uploads/sites/3/2014/04/DOMRACN_thm_Jul13_pressRel.pdf

⁴⁸⁵ CPS, Rape and Sexual Offences – Chapter 15: Disclosure and Third Party Material. <www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/disclosure_and_third_party_material/> [accessed July 2016].

it is a consideration that is kept under constant review as part of the case building. There were cases in the HMCPSI review where the contents of the medical records and/or counselling notes were disclosable under the CPIA 1996. Unfortunately, in four cases the HMCPSI review found the audit trail was insufficient to indicate any consideration of how the contents would have affected the realistic prospect of conviction.

In two cases where the prosecution failed to consider disclosure at all, the review found that the failure to properly deal with disclosure could potentially have had an adverse effect on the outcome (i.e. if the evidence had been disclosed, it might have lead to the case being withdrawn or the failure to secure a conviction). One case was dropped due to disclosure issues not being dealt with promptly.⁴⁸⁶ In six cases, prosecutors did not consider whether the information impacted on the realistic prospect of conviction and for three of those six cases the prospect of conviction was affected by the material. However, the CPS failed to take the appropriate course of action at the right time in any of these cases and the defendant was acquitted after trial.

Blanket disclosure

Despite the discretionary nature of the disclosure obligations in relation to third parties, there has been an increased tendency for the prosecution to conduct ‘blanket disclosure’. This involves the prosecution unnecessarily disclosing material about the complainant to the other side without due consideration to the disclosure test. This was an area of concern in the HMCPSI review. The review found that it, in cases where medical records and/or counselling notes were disclosed, some of the

⁴⁸⁶ Para 2.5.

disclosure was appropriate. However, in seven cases more material was disclosed than should have been. The over-disclosure did not have an adverse impact on the case itself, but was a breach of the complainant's right to respect for private and family life under Article 8 ECHR.⁴⁸⁷ In these cases of over-disclosure, the prosecutor had disclosed the whole document and failed to redact the material sufficiently, or even at all. For example, in one case, over 300 pages of medical records were disclosed when only a limited number of entries were disclosable.⁴⁸⁸ Furthermore, the review found that prosecutors were not always recording their decision-making on a disclosure record sheet, as required by the CPS disclosure manual. The lack of a proper audit trail made it difficult to assess the adequacy of decision making and the actions carried out. An analysis of CPS case files on this issue is one area for possible further research. Nevertheless, this apparent tendency towards over-disclosure is concerning because of the infringement of the complainant's privacy and it highlights that the prosecution are not complying with the statutory requirements under the CPIA 1996.

The disclosure of third party material is an important issue. These problems show that there needs to be a strengthening of processes and systems and more rigorous and considered decision-making. In adopting an approach whereby these private and often sensitive documents are disclosed as a matter of course, when they have no bearing or relevance to the case, is disservice to the rape complainant. Furthermore, it can unfairly intervene with the case success, thereby attrition, if the failure to

⁴⁸⁷ Article 8 provides that everyone has the right to respect for his private and family life, his home and his correspondence.

⁴⁸⁸ HMCPSI, *Disclosure of medical records and counselling notes* (July 2013) 9 http://www.justiceinspectors.gov.uk/crown-prosecution-service/wp-content/uploads/sites/3/2014/04/DOMRACN_thm_Jul13_rpt.pdf [accessed July 2016].

adhere to the CPIA 1996 obligations causes difficulties in the run up to trial and even derail the trial, thereby impacting directly on the complainant.⁴⁸⁹

In light of the HMCPSI review's findings, it is questionable whether the CPS is correctly identifying material that may undermine the prosecution. The issue came before the Court in *M v Director of Legal Aid Casework*.⁴⁹⁰ The case is noteworthy because the court admonishes the CPS for issuing witness summons without giving proper consideration to whether the records/material may be relevant or not. In this case, the claimant (M) was an Afghan national who had been in the United Kingdom for three years and did not speak English very well. She was married in 2012 and the marriage lasted six months. During that time, M alleged that her husband (X) had raped her. X was currently facing two counts of rape to be heard in the Crown Court. M and her family had been supported by a charity providing care and services for victims of torture, cruelty and human rights abuses. M had more than 20 counselling sessions with them. A small part of those sessions concerned her abuse at the hands of X.

The CPS informed M that they were seeking a witness summons in the Crown Court proceedings to gain access to her counselling notes. The summons was general in nature and sought the notes on the basis that the material contained in them might undermine its case or assist that of the defence. M opposed disclosure of her counselling notes, claiming confidentiality.

M sought permission to apply for judicial review of the refusal to grant her civil legal aid to allow her to be represented at the Crown Court. This hearing was to resist the application for a witness summons requiring disclosure of her confidential

⁴⁸⁹ HMCPSI, *Thematic Review of the CPS Rape and Serious Sexual Offences Units* (Feb 2016) [4.66] http://library.college.police.uk/docs/RASSO_thm_Feb16_rpt.pdf [accessed December 2016].

⁴⁹⁰ [2014] EWHC 1354; [2014] A C D 124.

counselling records. Her application was granted. The Court followed *R (on the application of B) v Stafford Combined Court*⁴⁹¹ and held that M's applications for exceptional case funding had to be seen against a background where she had clear and unequivocal entitlement to be heard on a witness summons. This summons sought to circumvent the confidentiality of her medical records and she therefore had the right to be heard on the issue.⁴⁹²

The Court held the decision to refuse to grant civil legal aid failed to consider the relevance of the notes in any detail or the issue of admissibility at all. As the wrong test was applied, it led to an incorrect conclusion about the prospect of success. Accordingly, permission to bring judicial review proceedings was granted and the decisions made by the CPS were quashed. Coulson J held that civil legal aid under the exceptional case funding provisions in section 10 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPOA 2012) is available to a witness who opposes an application for a witness summons seeking production of her medical or other such records. The court applied *R (TB) v Stafford Crown Court* and said that such a witness has an unequivocal right to be heard on the application.⁴⁹³

The Court noted that:

It is becoming increasingly common for the CPS to issue witness summonses of this kind, seeking medical and other such records concerning a complainant in an assault or sex case. In my experience, these applications are often made somewhat lazily, in the belief that, if there are some records which may have some relevance, the CPS is fulfilling its obligations to the defendant, and to the administration of

⁴⁹¹ [2006] EWHC 1645 (Admin), [2007] 1 WLR 1524.

⁴⁹² Para [15], [17].

⁴⁹³ [2006] EWHC 1645 (Admin), [2007] 1 WLR 1524.

justice, by issuing the witness summons and then putting the burden of resolving the issues raised onto others (namely the defendant, the complainant and the judge).⁴⁹⁴

Coulson J held that considerably greater analysis is required before any such summons is issued. As a general rule, it is not good enough merely to request the documents on the general basis that they might undermine the prosecution or help the defence.⁴⁹⁵ This suggests that the practice of blanket disclosure is a practice that may be unfairly intervening the complainant's privacy. For this reason, better training of prosecutors on the issues, obligations of the disclosure framework and relevance of the material is needed. It is important to ensure that the CPS adopt a consistent and principled approach to decision-making in this area.

Unclear whether police have obtained complainant's consent to disclose

The disclosure regime is explicit that prosecutors need to seek the consent of the complainant before there is any disclosure under the CPIA 1996 of medical records or counselling notes to the defence. According to Leahy, however, in practice, it can be difficult to ascertain whether a complainant had actually consented to disclosure.⁴⁹⁶ The HMCPSP review considered the forms the police use to obtain consent and concluded that some of the forms only sought consent for the police to

⁴⁹⁴ *ibid* [12] (Coulson J).

⁴⁹⁵ *Archbold Criminal Pleading Evidence and Practice* (2015 edn), Chapter 8 - Oral Testimony of Witnesses, Section A: Securing Attendance of Witnesses, Production of Documents, etc, (1) Summons to witness to attend Crown Court para [8-13].

⁴⁹⁶ S Leahy, 'Too much information? Regulating disclosure of complainant's personal records in sexual offence trials' [2016] Crim LR 229.

obtain the material and then to pass it on to the prosecutor, while others also sought consent for disclosure to the defence where appropriate under CPIA 1996.⁴⁹⁷

In addition to the different forms being used by the police, the HMCPSI review, as discussed above, also found that in the majority of the cases reviewed, it could not see anything in the file to indicate whether full or partial consent had been obtained. With some exceptions, prosecutors did not appear to be asking the police to approach the complainant for consent. Therefore, it is possible that consent to disclosure was never obtained by either the police or by the CPS. In the 32 cases where material was actually disclosed, the complainant's consent had been obtained in seven and it was not possible to tell whether or not consent had been obtained in the remaining 25.⁴⁹⁸

The CPS take the view that if medical records/counselling notes are listed on the schedule used to list non-sensitive material⁴⁹⁹ the prosecutor can assume that the police will have obtained the complainant's consent to disclosure to the defence, unless the police say otherwise. In those circumstances, where the material is considered to be disclosable under the CPIA 1996, the complainant is not contacted prior to any disclosure to the defence. This approach is risky in view of the HMCPSI file examination findings regarding blanket disclosure and is further compounded by the lack of a national police form for seeking a complainant's consent.⁵⁰⁰ Relying on the use of the incorrect, outdated or unreliable material schedule to determine

⁴⁹⁷ HMCPSI, *Disclosure of medical records and counselling notes : a review of CPS compliance with rules and guidance in relation to disclosure of complainant's medical records and counselling notes in rape and sexual offence cases* (July 2013) http://www.justiceinspectors.gov.uk/crown-prosecution-service/wp-content/uploads/sites/3/2014/04/DOMRACN_thm_Jul13_rpt.pdf [accessed July 2016].

⁴⁹⁸ HMCPSI, *Disclosure of Medical Records and Counselling Notes* (July 2013) para [3.8]

⁴⁹⁹ MG6C.

⁵⁰⁰ *ibid* para 3.2.

whether or not a complainant has consented does not provide the prosecutor with sufficient assurance or the complainant with sufficient protection.⁵⁰¹

Problems of ‘under-disclosure’

In other cases, and contrary to the problem of ‘over-disclosure’, the prosecution may be confronted with lack of access to relevant material that may lead to a problem of ‘under-disclosure’. The prosecution may be faced with difficulties if either the third party or the complainant refuses the disclosure request, which is common when the request relates to medical records or counselling or therapy notes. Depending on the stage of the case, either the police or the CPS will need to obtain consent from the complainant in order to gain access to the records to enable disclosure to take place. Prosecutors need to record on the relevant documentation the reasons for their decisions for requesting disclosure of medical records and/or counselling notes.⁵⁰² The prosecution must inform the complainant of the disclosure request and must explain what will happen if she refuses. There are three possible outcomes depending on the complainant’s attitude toward disclosure of the material:⁵⁰³ full consent, qualified consent and no consent.

Full consent occurs where the complainant accedes to the request and disclosure is made. The police and prosecutor access records, serve them as evidence in its case

⁵⁰¹ Ibid para 3.3.

⁵⁰² Recorded on both the ‘Disclosure Record Sheet’ and the Prosecution Strategy Document’, CPS Legal Guidance.

⁵⁰³ Mind, *Achieving justice for victims and witnesses with mental distress: A mental health toolkit for prosecutors and advocates* <www.cps.gov.uk/publications/docs/mind_toolkit_for_prosecutors_and_advocates.pdf> [accessed July 2016].

and/or disclose to the defence as unused material⁵⁰⁴, as appropriate under CPIA rules.⁵⁰⁵

Qualified consent occurs where the complainant only allows the police and CPS to view the material but not the defence. In this instance, the prosecution must decide whether the material supports the prosecution case or whether it will become unused material. If the material meets the disclosure test, the prosecution will seek the complainant's consent to disclose to the defence. If the complainant refuses to allow this material to be disclosed to the defence, the CPS can consider whether PII is applicable. If the CPS does decide to make a PII claim the complainant is entitled to put her views before the court and the court will make a decision.⁵⁰⁶ The procedural requirements for a PII claim are discussed further below.

No consent occurs where the complainant refuses the disclosure request and the prosecution believes that there is disclosable information in existence it may be appropriate to apply for a witness summons to gain access to the material.⁵⁰⁷ The SOIT officer would inform the complainant of this fact. This application would be made by the prosecution and it would be heard before a judge who would make a ruling on the disclosure issue. In order to bring about disclosure of any material, section 2 of the Criminal Procedure (Attendance of Witnesses) Act 1965 is employed

⁵⁰⁴ Unused material is material that may be relevant to the investigation that has been retained but does not form part of the case for the prosecution against the accused, CPS 'Disclosure Manual' para [1.6].

⁵⁰⁵ *R v J* [2010] 3 Archbold Review 2, CA (04/03/2010) is an example of how the courts approach this issue. In this case, the Court held that a judicial order for disclosure of social service documents relating to a witness does not give either prosecution or defence carte blanche to use the documents in any way they see fit. It is imperative the prosecutors seek informed consent from the complainant at all times. This applies both in relation to accessing medical records or expert evidence and any later need to disclose such information to the defence.

⁵⁰⁶ *R (on the application of TB) v Stafford Combined Court* [2006] EWHC 1645 (Admin); [2007] 1 W L R 1524.

⁵⁰⁷ The source of law for applications made in the Crown Court is Section 2 Criminal Procedure Act (Attendance of Witnesses) Act 1965 and Part 28 Criminal Procedure Rules sets out the procedure for witness summons.

and the prosecutor may make an application for a witness summons causing the third party to produce the material to the court.⁵⁰⁸ Where no permission is given for the release or service of medical records, the complainant has a right to make representations to the court as to this decision.⁵⁰⁹

Problems arise in instances where the complainant does not give her consent to allow information about her mental health to be disclosed to the defence. Such refusal can have implications for the success of the prosecution. In summary, therefore, when the complainant or third party either says “no” or gives a qualified “no” to the disclosure request, there are three possible options available to the prosecution:

- apply for a witness summons,
- claim Public Interest Immunity (PII), or
- discontinue the prosecution.

There are, however, problems relating to these three options. Particularly problematic is how the prosecutions’ decision to discontinue the prosecution is related to attrition. These are discussed next.

Witness summons: section 2 Criminal Procedure (Attendance of Witnesses) Act 1965

The disclosure of material that has been gathered or created by a third party presents challenges for the CPS. Due to the private nature of medical and mental health material, disclosure is likely to be contested by either the complainant, the third party or both. Consequently, there will be times when the prosecution seeks access, but the

⁵⁰⁸ The application should be made as soon as possible after the case has been sent for trial to the Crown Court – Judiciary of England and Wales, ‘Judicial Protocol on the disclosure of unused material in criminal cases’ (December 2013) para [52].

⁵⁰⁹ R (on the application of TB) v Stafford Combined Court [2006] EWHC 1645 (Admin).

third party is uncooperative or refuses to allow use due to the sensitive and confidential nature of the material. Nevertheless, the Disclosure Protocol states that the prosecution should not leave the matter. In order to bring about disclosure of any material, section 2 of the Criminal Procedure (Attendance of Witnesses) Act 1965 is employed. The prosecutor may make an application for a witness summons causing the third party to produce the material to the court.⁵¹⁰ Although this may be a pathway, as will be seen below, this may be problematic where the complainant makes a Public Interest Immunity (PII) application regarding the material. The procedure to apply for a witness summons in order to obtain disclosure of material from a third party is contained within Part 28 of the Criminal Procedure Rules 2013.

The complainant is allowed the opportunity to make representations to the court about disclosure. The importance of this right in the context of rape allegations is demonstrated in *R (on the application of TB) v Stafford Combined Court*.⁵¹¹ In this case, the Court considered an application for disclosure of psychiatric medical records in relation to TB, a complainant then aged 15, in allegations of sexual activity with a child. Although the NHS Trust advanced the argument that the confidentiality was that of the patient, in the context of a defence of invention and fantasy, the trial judge considered the records to be plainly relevant and that the gravity of the criminal allegation took precedence over issues of confidentiality. He ordered disclosure.

⁵¹⁰ The application should be made as soon as possible after the case has been sent for trial to the Crown Court – Judiciary of England and Wales, ‘Judicial Protocol on the disclosure of unused material in criminal cases’ (December 2013) para [52].

Section 2 of the 1965 Act provides:

1) This section applies where the Crown Court is satisfied that –

a. A person is likely to be able to give evidence likely to be material evidence, or produce any document or thing likely to be material evidence, for the purpose of any criminal proceedings before the Crown Court, and

b. It is in the interests of justice to issue a summons under this section to secure the attendance of that person to give evidence or to produce the document or thing.

⁵¹¹ [2006] EWHC 1645 (Admin); [2007] 1 WLR 1524.

The Trust notified the Official Solicitor, who was concerned about the infringement of TB's Article 8 rights and sought to challenge the judge's ruling. The judge invited TB to attend court, which she did. No effort was made to ensure she was represented, although she was able to telephone the Official Solicitor from the court. Rather than delay the trial, undeniably under pressure, TB reluctantly agreed to disclosure. On an application for a declaration that TB was entitled to service of the application and the right to make representations as to the order, the court held that 'the burden of protecting TB's privacy should not be placed on the Trust. The burden resides with the court and she herself was entitled to notice and proper opportunity for representation.'⁵¹² The case is authority for the principle that the overriding objective of the Criminal Procedure Rules and procedural fairness in light of Article 8, requires that where an application for a witness summons has been made for the purpose of requiring an NHS Trust to disclose a patient's medical records, the patient should be given notice of that application and be allowed the opportunity to make representations before any order is made. However, this could prove difficult for the complainant if she is unable to attend court or simply feels pressure, as a result of the situation, to disclose the information.

Application for a witness summons involves a more stringent test than the disclosure test that applies to the prosecution. Material sought under a witness summons must be 'likely to be material evidence' and this has been construed to mean 'immediately admissible per se.'⁵¹³ For a rape complainant, this means that the issue of 'materiality' under section 2(2) Criminal Procedure (Attendance of Witnesses) Act 1965 is a critical issue to be determined by the court. Material evidence can be used in cross-examination, but if the information is being deployed solely to undermine

⁵¹² Quoted in *R v Doski* [2011] EWCA Crim 712, 713-14 (note).

⁵¹³ *R v Derby Magistrates' Court ex parte B* [1995] 4 All ER 526.

credibility, it will not meet the ‘material evidence’ test. Therefore, an application for a witness summons will only be made where the prosecution considers that the material sought is likely to be material evidence in the proceedings. Evidence is material if it is relevant to an issue in the case.⁵¹⁴ *R (on the application of TB) v Stafford Combined Court* provides that the third party has the right to make representations to the court against the issue of a witness summons. This means that the ‘document’ must itself be likely to be material evidence. A witness summons will not be issued for documents which will not themselves constitute evidence in the case but merely gives rise to a line of enquiry which might result in evidence being obtained.⁵¹⁵ The legitimate purpose of a summons under section 2 of the Criminal Procedure (Attendance of Witnesses) Act 1965 is to procure documents that are likely to be material evidence – not just those which are likely to assist a ‘relevant line of inquiry or challenge’.⁵¹⁶ Therefore, material which might simply be useful in cross-examination cannot be extracted from third parties by use of a witness summons. For a rape complainant, this means that the issue of ‘materiality’ under section 2(2) Criminal Procedure (Attendance of Witnesses) Act 1965 is a critical issue to be determined by the court. However, the decision about disclosure of the material will be dependent on the exercise of judicial discretion.⁵¹⁷ There is a potential danger that material relating to the complainant’s mental health could be characterised as material and relevant information. The next chapter makes the argument as to why it should not be characterised in this way.

As stated above, where the documents are desired by the defence for the purpose of cross-examination merely on credibility, they are not admissible in evidence, and fail

⁵¹⁴ *R v Reading Justices ex parte Berkshire County Council* [1996] 1 Cr App R 239.

⁵¹⁵ *R v Alibahi* [2004] EWCA Crim 681.

⁵¹⁶ *R v H* [1997] 1 Cr App R 176.

⁵¹⁷ L Ellison ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13(1) E & P 28, 38.

to satisfy the statutory test of ‘materiality’, and so are not disclosable. If it can be shown that the objective is not primarily to contradict the complainant, but rather to elicit evidence which is helpful to the defence, the application may be granted. Leahy notes that there is a hidden danger that even if the personal records do not reveal evidence of mental health issues, it is likely the documents could still contain other information which could be used by the defence to undermine the complainant’s credibility. For example, ‘social work or medical files may contain references to drug use or incidents with social workers which could be introduced to suggest that a complainant is not a worthy or reliable victim’.⁵¹⁸ These strategies are liable to unfairly influence jurors’ perceptions of the complainant’s credibility.

It is difficult to determine, in the absence of recent empirical research, the frequency of disclosure applications in this area. We do have the official findings from Kelly, Temkin and Griffiths research, but this is dated. Nevertheless, an increasing tendency to seek disclosure of personal records has been highlighted in cases.⁵¹⁹ In *H* it was suggested by Sedley J (as he then was):

[i]t has become standard practice for defence lawyers in rape and indecency cases to seek to compel the production of any social services, education, psychiatric, medical or similar records concerning the complainant, in the hope that these will furnish material for cross-examination.⁵²⁰

What is the problem with the ‘likely to be material evidence’ test? Is mental health information ‘material evidence’? Whether the information is likely to be material

⁵¹⁸ S Leahy S, ‘Too much information? Regulating disclosure of complainant’s personal records in sexual offence trials’ [2016] Crim LR 229, 231.

⁵¹⁹ Reading Justices *Ex Parte Berkshire CC* [1996] 1 C App R 239, 542 and *R v Brushett* (2000) All ER 2432.

⁵²⁰ *R v H* [1997] 1 Cr App R 176, 177–178.

evidence will relate to the credibility of the complainant in any rape prosecution. An applicant for third party material must state why the document is likely to be material evidence and why it is in the interests of justice for a summons to be issued.⁵²¹ The reasoning of why the material is of importance to the case needs to be set out. This is especially pertinent in relation to medical records; a judge must be alert to balance the rights of rape complainants against the needs of the defence⁵²² due to the confidential and private nature of the material. The court must not issue a summons unless it is satisfied it has been able to take adequate account of the duties and rights, including rights of confidentiality, of the proposed witness or the person to whom the document relates.⁵²³ The need to protect the confidentiality of medical records and mental health material may be outweighed by the public interest in the investigation and prosecution of crime and the openness of court proceedings.

Public Interest Immunity: applications for non-disclosure in the “public interest”

The second pathway the prosecutor can undertake when a complainant objects to disclosure is PII. This is another complex procedure and its use is fraught with difficulties. If a rape complainant receives a witness summons she may object to the production of the material on the grounds of Public Interest Immunity (PII). Section 16 of the CPIA 1996 allows the prosecution or the complainant to apply to the court for an order to withhold material which would otherwise fall to be disclosed, if that

⁵²¹ Rule 28.3(2)(b) of the Crim PR.

⁵²² Judicial Protocol (2013) para [62].

⁵²³ The courts have been clear that it is not permissible for an applicant to embark speculatively on an application for disclosure in the hope that something helpful will emerge, often referred to as a ‘fishing expedition.’ For example, it is not acceptable to seek the entirety of the files held a local authority in cases where it is known there has been a social services background in regards to the complainant: Rook & Ward para [25.86].

material is subject to PII.⁵²⁴ One of the categories in section 16 of the CPIA 1996 is ‘sensitive material’ which includes material given in confidence and material relating to the private life of a witness.⁵²⁵ Therefore, material relating to the complainant’s mental health may come under the protection of the PII rule, as it would not be in the public interest to allow the disclosure of such sensitive and private material.

A non-disclosure order may be granted where disclosure would give rise to a real risk of serious prejudice to an important public interest, such as confidentiality as between doctor and patient.⁵²⁶ However, where PII is claimed, the court must perform a balancing exercise, ‘balancing on the one hand the desirability of preserving the public interest in the absence of disclosure against, on the other, the interests of justice’ in the sense of fairness to the defendant.⁵²⁷ The complainant is given the opportunity to make representations before the court regarding the sensitive material. The AG Guidelines advise that before making the application the prosecution ought to disclose as much of the material as possible, for example by providing redacted copies or summaries to the defence.⁵²⁸

Why might disclosure of information about a complainant’s mental health be against the public interest? Such information is both private and confidential, due to the confidential nature of the doctor/patient relationship and the nature of the information itself. An individual’s private information must be dealt with respectfully and in a delicate manner. It is both material given in confidence, and material relating to the private life of a complainant, therefore Article 8 rights are

⁵²⁴ s16 of the CPIA allows a person claiming to have an interest in the sensitive material to apply to the court for the opportunity to be heard at the application.

⁵²⁵ The Code of Practice, Part II of the CPIA, para [6.12].

⁵²⁶ CPS, ‘Rape and Sexual Offences – Chapter 15: Disclosure and Third Party Material.’ <www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/disclosure_and_third_party_material/>

⁵²⁷ *R v Governor of Brixton ex parte Osman* [1992] 1 All ER 108, 116.

⁵²⁸ AG’s Guidelines, para [65].

engaged.⁵²⁹ For these reasons, it would be in the public interest to prevent the disclosure of mental health material as the complainant's right to privacy extends to privacy of confidential material regarding her mental health.

In the context of a rape allegation, what kind of material would be subject to PII? This would encompass any material relating to the complainant's mental health, such as psychiatric or psychological reports, and is therefore classifiable as information given in confidence and relating to the private life of the complainant. In those circumstances, the test set out in *R v Keane*⁵³⁰ should be followed so that 'if the disputed material might prove a defendant's innocence or avoid a miscarriage of justice, the balance comes down resoundingly in favour of disclosure.'⁵³¹ This is consistent with the 'golden rule' as established in *R v H; R v C*, that disclosure should be made of material held by the prosecution which weakens its case or strengthens that of the defence. Having said that, the duty to disclose is not absolute⁵³² as the CPIA 1996 makes provision for material not to be disclosed where the prosecution has made a PII application and the court concludes that it is not in the public interest to disclose the material.⁵³³

Disclosure is a fundamental aspect of a fair trial that upholds the equality of arms principle and ensures the defendant's rights. Yet the defendant and complainant's rights should not be automatically viewed as oppositional. Respecting the rights of a complainant in relation to her right to privacy of mental health material does not

⁵²⁹ Article 8 provides a right to respect for one's 'private and family life, his home and his correspondence', subject to certain restrictions that are 'in accordance with law' and 'necessary in a democratic society'.

⁵³⁰ [1994] 1 WLR 746 at 751.

⁵³¹ Rook and Ward, para [25.95].

⁵³² *R v H; R v C* [2004] 2 AC 134, para [147].

⁵³³ ss3(6), 7A(8), 8(5) of the CPIA 1996.

necessarily bring about a 'reduction in the rights of the accused.'⁵³⁴ However, the above discussion highlights how the complainant's right to privacy can be overshadowed or not given due weight.

Conclusion

This chapter has examined the relevance and function of disclosure to rape prosecutions. It considers the relationship between the disclosure process and mental health and set out the problems of this process. The prosecution is under an obligation to disclose to the defence any material which may undermine its case or assist that of the defence. Different tests apply regarding material in possession of the prosecution and material in possession of third parties. Does the disclosure process, which makes provision for information about the complainant's mental health to be disclosed to the defence, unfairly affect an already vulnerable group? The research suggests prosecutors do not always properly consider whether the material needs to be disclosed to the defence and secondary problems of 'over disclosure' of records in their entirety.⁵³⁵ Furthermore, prosecutors did not appear to consistently consider whether a complainant's consent had been obtained regarding disclosure to the defence.⁵³⁶ This is in breach of the complainant's right to privacy.

If prosecutors do not consider whether material is disclosable under the CPIA 1996, they risk failing to disclose material which should be given to the defence. In addition to the failure to comply with the CPIA 1996, this omission could result in a miscarriage of justice. If disclosure of material relating to the complainant does not

⁵³⁴ J Doack, *Victims' Rights, Human Rights and Criminal Justice: Reconceiving the Role of Third Parties* (Hart Publications 2008) 47.

⁵³⁵ HMCPSI, *Disclosure of Medical Records and Counselling Notes* (July 2013).

⁵³⁶ HMCPSI, *Disclosure of Medical Records and Counselling Notes* (July 2013).

occur there is a possibility that the case may be discontinued, thereby contributing to the rate of attrition.

The disclosure obligations placed upon the prosecution are essential to the criminal process and to the accused's right to a fair trial. When conducted properly, all material that is relevant to the outcome of the trial should be placed before the court.⁵³⁷ Nonetheless, the disclosure requirements give rise to a conflict between the right of the accused to a fair trial and the complainant's right to privacy. Refusal by a complainant to allow the prosecution to disclose medical records or material relating to the complainant's mental health may mean a case is discontinued. A court may order disclosure of mental health records, against a complainant's direct non-consent of disclosure. In these cases, a complainant may make a PII application to resist disclosure. Currently, it seems that, when deciding on PII application, courts have generally found the right to privacy outweighs the rights of the accused, particularly where relevance is unlikely.

In order to understand why these materials are thought to be relevant and probative, it is helpful to consider the relationship between the disclosure process and the content of the material that is being sought. The relationship between disclosure procedure and the area of mental health is a complex one. It is necessary to first define the type of material and, subsequently, why it is perceived to be relevant to determinations of credibility. This leads to two inevitable questions: firstly, what is the substance of the material? Secondly, why is this material being sought? The next chapter examines how there are substantial problems created by seeking this type of material.

⁵³⁷ As stated at the beginning of this chapter relevant material' is information which may prove or disprove the issues disputed by the prosecution and defence.

This thesis examines the relevance and impact of mental health conditions in the investigation and prosecution of rape allegations. This chapter sets out the means by which personal information about the complainant, relating to either her mental health (e.g. medical records) and/or any therapy or counselling which has taken place, is disclosed to the defence. The next chapter considers the relevance and use made of such information at trial, and examines how the material is adduced with a view to undermining complainant credibility. The duty of the CPS to disclose this information to the defence raises concerns as to how disclosure affects a group vulnerable to predation and less likely to report allegations of rape. The problem of attrition, as set out in Chapter 1, is compounded by placing additional procedural obstacles, such as having to go before court to oppose the application, possibly unrepresented, before an already significantly vulnerable category of complainant. This supports the proposition that the incidence of mental health issues can be significant among both victims of rape and those complainants whose cases are not progressed.

This chapter examined the problems associated with pre-trial disclosure and has focused on process as a basis for the final chapter. The next chapter asks whether the disclosure process, which makes provision for information about the complainant's mental health to be disclosed to the defence, unfairly affects this group of complainants. The question of the perceived use and relevance of the documents is discussed in the next chapter.⁵³⁸

The focus on procedure is important as the disclosure process is a key part of the investigation and prosecution of rape offences. The steps taken by the CPS have a

⁵³⁸ See sub-heading: 'The Complainant's Mental Health: What is the Nature and Relevance of the Material?'

direct impact on complainant credibility, and the type of material relating to the complainant's mental health, disclosed to the defence and adduced at trial. At its simplest, the decisions and actions that occur in pre-trial stages have the potential to influence juror assessments of credibility at trial. Where the defence gains access to the complainant's medical or counselling records, by means of the disclosure process, questions may be asked at trial with a view to implying that the complainant is unreliable. This matter is considered in the next chapter, which examines how disclosure, as it concerns mental health material, encourages a misconception that women who are mentally unstable make false allegations of rape. The current use of the disclosure procedure is to allow the complaint's medical records, such as psychiatric reports therapy notes, to be used to undermine her credibility.⁵³⁹

CHAPTER 6: The Admission of Mental Health

Evidence at Trial

Introduction

This thesis examines the relevance and impact of a complainant's mental health on the investigation and prosecution of a rape allegation. Previous chapters have discussed how the incidence of mental health issues are significant amongst both complainants of rape and those complainants whose cases are not progressed. Before this, discussion has been situated in a pre-trial context. The final attrition point in the criminal justice process is an acquittal, therefore this chapter focuses on the trial process including the admission of material relating to the complainant's mental health at trial and its relevance and potential bearing on the outcome of a case. It

⁵³⁹ L Kelly, J Temkin and S Griffiths, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* (Home Office Online Report 20/06, 2006) Chapter 4.

considers the issues surrounding disclosure of the complainant's personal information to the court and how such material can be used to discredit the complainant.

This chapter is divided into two parts: the perceived relevance of material relating to the complainant's mental health, and the consequences of its use at trial. Following the approach set out in Chapter 5, this chapter also considers the relationship between mental health conditions and rape complainants, encompassing both complainants with pre-existing mental health conditions and those who seek counselling or therapy *following* a rape.⁵⁴⁰ We have seen that existing research shows that rape complainants are often likely to suffer from a mental health condition.⁵⁴¹ Further to this, there is a correlation between having been the victim of a sexual assault and developing mental health issues, for example, depression or anxiety. Previous chapters have discussed the fact that the existing vulnerability of mental health issues may relate to the likelihood of predation; it can also increase the likelihood of a complainant withdrawing an allegation, and/or the decision of the police or the CPS to discontinue the case, both of which impact attrition rates.

Following a rape, it is not uncommon for the complainant to seek and obtain emotional support in the form of counselling or therapy. This may be a voluntary decision on the part of the complainant, or it may be offered by the police as part of the investigation, or it may arise from the complainant's attendance of an SARC.⁵⁴²

The prosecution is under a duty to inform the defence of any counselling which takes

⁵⁴⁰ This approach is taken throughout the thesis, considering firstly where the complainant suffers from a pre-existing mental health condition (i.e. the condition existed before and is unrelated to the offence), and second, where the offence causes a mental health condition in the complainant.

⁵⁴¹ B Stanko and E Williams, 'Reviewing Rape and Rape Allegations in London: What are the Vulnerabilities of the Victims who Report to the Police?' in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009).

⁵⁴² For example, The Havens offers counselling and other emotional support to complainants <www.thehavens.org.uk/visiting-us/follow-up-care/> accessed September 2015.

place, as it can be viewed as a form of pre-trial discussion and, possibly, witness coaching.⁵⁴³ So if a complainant does receive counselling after a rape, it is likely the defence will make a disclosure application to access those records created during the course of the counselling. From an evidential perspective, the defence seeks access to counselling records because they may contain information that concerns how events relating to the allegation unfolded. Further, these records are likely to contain material which pertains to the complainant's credibility. This includes testimonial factors such as the quality of her perception of events at the time of the offence, her state of mind, and how the receipt of therapy could have influenced her memory of the event in the interim.⁵⁴⁴

Terminology – counselling / therapy

Personal information about the complainant encompasses both medical records relating to mental health and/or any therapy or counselling which has taken place. Therapy, in the broad sense, covers a range of treatment approaches and includes counselling⁵⁴⁵ but does not include physical treatments. Psychotherapy includes treatment of emotional and behavioural disturbance, and is intended as treatment for an individual who has been highly traumatised.⁵⁴⁶ The treatment focuses on the complainant's emotions, cognition and behaviour.⁵⁴⁷ Psychotherapy includes interventions designed to decrease distress and psychological symptoms or to

⁵⁴³ CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance' (Implementing the Speaking up for Justice Report). Whether the complainant has received counselling is also a consideration listed on the CPS 'Rape Prosecutions Advice/Review Checklist'

http://www.cps.gov.uk/legal/p_to_r/rape_and_sexual_offences/appendix_d/

<www.cps.gov.uk/publications/prosecution/pretrialadult.html> accessed July 2016.

⁵⁴⁴ S Bronitt and B McSherry, 'The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the "rape shield"?' (1997) 8(2) Criminal Law Forum 259, 263.

⁵⁴⁵ The two terms are used interchangeably.

⁵⁴⁶ CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance' at [2.4.2].

⁵⁴⁷ *ibid* [2.1].

improve ‘adaptive and personal functioning’ using counselling or activities following a specific treatment plan.⁵⁴⁸ Counselling seeks to address the impact of the incident on the complainant; improving self-esteem and confidence and providing the complainant with information as regards dealing with and avoiding abusive situations.⁵⁴⁹

As a rape allegation proceeds to trial, it is common for the defence to seek disclosure of the complainant’s medical records, which can include therapy notes with a psychologist or counsellor.⁵⁵⁰ However, research on the number of applications is dated. This chapter considers the use of this material and then assesses whether such information is relevant and ought to be adduced at trial. Furthermore, a rationale for adducing this material is examined using some examples of this material where it has been admitted and placed before a jury.

This chapter also analyses some of the attitudes surrounding mental health and rape complainants and the perceived relevance or probative value of such material. A recurring misconception is the level of suspicion that an allegation is false or fabricated where a complainant has a mental health condition. Another common misconception is that complainants with mental health issues are less reliable witnesses and may be confused about the allegation or the events that did occur, or will be entirely unable to distinguish fact from fantasy. If counselling notes are sought they can be deleterious to a complainant’s credibility: the existence of any previous allegations can support an inference or argument that a current allegation is false. Alternatively, these notes may support an argument as to the defendant’s

⁵⁴⁸ *ibid.*

⁵⁴⁹ CPS, ‘Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance’ [2.4.1].

⁵⁵⁰ L Kelly, J Temkin and S Griffiths, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* (Home Office Online Report 20/06, 2006) Chapter 4.

reasonable belief of consent, making a defence for the accused from a tool intended to support vulnerable victims.

The following section examines questions around this particular line of defence and the defence's access to this personal information by examining the association between mental health issues and rape complainants. Before examining Parts I and II of this chapter, it is necessary to discuss the relationship between rape complainants and mental health.

The relationship between rape complainants and mental health issues

Seeking information about the complainant's mental health, as a defence trend, is commonly interpreted to arise from restrictions upon sexual history evidence.⁵⁵¹ In previous decades, particularly the 1990s, critical discussion in the area of sexual offence reform has centred on the cross-examination of rape complainants and the use of sexual history evidence at trial.⁵⁵² England and Wales have 'rape shield' legislation by virtue of section 41 of the YJCEA 1999 which, subject to exceptions, prohibits questions being asked or evidence adduced at trial about the complainant's

⁵⁵¹ Other significant changes in the history of rape law reform include the abolishment of a mandatory corroboration warning, changes to the evidential status of recent complaints, a statutory definition of consent, and, relevant to the present discussions, the restriction of the use of sexual history evidence at trial. For critical discussion see P Mirfield, "'Corroboration" after the 1994 Act' [1995] Crim LR 448; P Lewis, 'A Comparative Examination of Corroboration and Caution Warnings in Prosecutions of Sexual Offences' [2006] Crim LR 889; A Ashworth and J Temkin, 'The Sexual Offences Act 2003: Rape, Sexual Assault and the Problem of Consent' [2004] Crim LR 328; D A H Rodwell, 'Problems with the Sexual Offences Act 2003' [2005] Crim LR 290; J McEwan, 'Proving Consent in Sexual Cases: Legislative Change and Cultural Revolution' (2005) E & P 1; R v O [2006] EWCA Crim 556; [2006] Crim LR 918 (note).

⁵⁵² S Adler, 'The Relevance of Sexual History Evidence in Rape: Problems of Subjective Interpretation' [1985] Crim LR 769; J Temkin, 'Prosecuting and Defending Rape: Perspectives from the Bar' (2000) 27 JLS 219; S Easton, 'The Use of Sexual History Evidence in Rape Trials' in M Childs and L Ellison (eds) *Feminist Perspectives on Evidence* (Cavendish Publishing 2000) 167; J Temkin, 'Regulating Sexual History Evidence: The Limits of Discretionary Legislation' (1984) 33 I.C.L.Q 942; J Temkin, 'Sexual History Evidence – The Ravishment of Section 2' [1993] Crim LR 3; Report of the Advisory Group on the Law of Rape (the Heilbron Committee) (Cmnd 6352 1975); S Adler, *Rape on Trial* (Routledge & Kegan Paul Ltd 1987).

sexual history. The YJCEA 1999 was introduced in order to protect complainants from unnecessary and irrelevant enquiries into previous sexual relationships, but also to safeguard against further, often termed ‘secondary’, victimisation by restricting questioning about the complainant’s private sexual matters. But because the inferences that can be drawn from such lines of defence are still perceived as successful, the defence is then motivated to seek out evidence of this nature elsewhere. Although writing from an Australian standpoint, Bronitt and McSherry refer to England and Wales in their exploration of the use of mental health evidence. They posit that the objectives underlying reform of the admissibility of sexual history evidence are being undermined in practice.⁵⁵³ They suggest that defence counsel often seeks to circumvent section 41 by targeting the psychiatric, rather than the sexual, history of the complainant;⁵⁵⁴ and that the defence then looks to adduce psychiatric evidence (or other information relating to mental health) in order to discredit the complainant’s testimony in the eyes of the jury.⁵⁵⁵ Statistics for England and Wales appear to support this theory: Kelly, Temkin and Griffith’s research on sexual history evidence, which was conducted for the Home Office, followed rape cases over a three-month period in 2003. They discovered that third party disclosure applications were made in approximately a quarter of cases and medical records accounted for 22% of applications.⁵⁵⁶ In addition, Temkin has elsewhere documented

⁵⁵³ For the position and similar trends in other jurisdictions see: K Busby, ‘Discriminatory use of Personal Records in Sexual Violence Cases’ (1997) 9 *Canadian Journal of Women and the Law* 148-177; B Feldthusen, ‘Access to the Private Therapeutic Records of Sexual Assault Complainants’ (1996) 75(4) *The Canadian Bar Review* 538-563; E McDonald, ‘Resisting Defence Access to Counselling Records in Cases of Sexual Offending: Does the Law Effectively Protect Clinician and Client Rights?’ (2013) 5(2) *Sexual Abuse in Australia and New Zealand* 12-20; T Wilkinson-Ryan, ‘Admitting Mental Health Evidence to Impeach the Credibility of a Sexual Assault Complainant’ (2005) 153 *University of Pennsylvania Law Review* 1373.

⁵⁵⁴ S Bronitt and B McSherry, ‘The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the “rape shield”?’ (1997) 8(2) *Criminal Law Forum* 259, 260-1.

⁵⁵⁵ L Kelly, J Temkin and S Griffiths, *Section 41: An Evaluation of New Legislation Limiting Sexual History Evidence in Rape Trials* (Home Office Online Report 20/06, 2006) Chapter 4.

⁵⁵⁶ *ibid* 25.

the strategy of circumnavigation described above.⁵⁵⁷ Lastly, research conducted in Canada also found a related increase in third party disclosure application of written records relating to the complainant following restrictions on the use of sexual history evidence.⁵⁵⁸

It does therefore appear that a shift has occurred as a result of restriction upon questioning the complainant's sexual history: defence counsel seek 'discreditable' material in the complainant's mental health and counselling records.⁵⁵⁹ The difficulty presented by this practice, from an evidential perspective, is that the material may have no logical bearing on a complainant's credibility and yet still damage it. Given society's prejudice about mental illness, it may be more prejudicial than probative, whether determining credibility or consent.⁵⁶⁰ As stated, examples of such prejudice include pre-formed opinions about rape complainants with mental health issues: that they are unstable and unreliable witnesses, untrustworthy, or prone to fantasy and attention-seeking. Temkin and Krahé share these assumptions of difficulty. They argue that disclosure applications regarding mental health records allows information to be pursued which only fosters negative attitudes and stereotypes about complainants in rape cases.⁵⁶¹ Victim support groups and mental health charities

⁵⁵⁷ J Temkin, 'Sexual history evidence – beware the backlash [2003] Crim LR 217-243.

⁵⁵⁸ K Busby, 'Discriminatory use of personal records in sexual violence cases' (1997) 9 Canadian Journal of Women and the Law 148-177; K Kelly, 'You must be crazy if you think you were raped: Reflections on the use of complainants' personal and therapy records in sexual assault trials' (1997) 9 Canadian Journal of Women and the Law 178-195; M Denike, 'Sexual violence and fundamental justice: on the failure of equality reforms to criminal proceedings' (2000) 20(3) Canadian Women's Studies 151-159.

⁵⁵⁹ *ibid.*

See also K Busby, 'Discriminatory use of personal records in sexual violence cases' (1997) 9 Canadian Journal of Women and the Law, 148-177; B Feldthusen, (1996) Access to the private therapeutic records of sexual assault complainants' (1996) 75(4) The Canadian Bar Review, 538-563.

⁵⁶⁰ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) E&P 28, 29.

⁵⁶¹ J Temkin and B Krahé, *Sexual Assault and the Justice Gap: A Question of Attitude* (Hart Publishing 2008) 151-2.

have also expressed concerns about the developing tendency to use such material at trial.⁵⁶²

When material of this nature is sought in order to be adduced at trial, this thesis finds that there are several potential motives. These include:

- i. Seeking admission of medical records to show that the complainant suffers from mental illness and therefore she is an ‘unreliable’ witness;
- ii. Seeking access to therapy records in order to show that:
 - a. the complainant has been a victim of previous sexual abuse and consequently may be confused as to what took place and/or has a history of making allegations of a sexual nature and therefore ought not to be trusted; and
 - b. the complainant has admitted feelings of blame or responsibility during the course of a counselling/therapy session and that therefore the defendant did have a reasonable belief in consent.

The impact upon complainant credibility, and therefore the likelihood of acceptance of the prosecution’s case, is manifold. Firstly, such information may unfairly undermine complainant credibility because inferences of the kind listed above are unfounded. For example, the link between mental illness and unreliability of testimony has been shown to be weak.⁵⁶³ And ‘vulnerability is not the same as unreliability.’⁵⁶⁴ Secondly, such inferences rely on assumptions about being a

⁵⁶² M Pedlar et al., *Silenced Witnesses* (MIND 2000); Victim Support, *Women, Rape and the Criminal Justice System* (Victim Support 1996).

⁵⁶³ D Englert, A Diserio and K Ryan, ‘The Prosecutor’s Guide to Mental Health Disorders’ (2007) 1 *The Voice* –American Prosecutors Research Institute Newsletter 1. As affirmed by the court in *R (on the application of B) v* (2009) EWHC 106 (Admin).

⁵⁶⁴ The Advocate’s Gateway, ‘Identifying vulnerability in witnesses and parties and making adjustments’: Toolkit 10’ (March 2017) para [1.2]

complainant of sexual violence – that someone who has been victimised in the past is either confused about what happened because repeat victimisation is perceived as unlikely (when in fact it is not, repeat victimisation is a vulnerability common to complainants⁵⁶⁵), or that the complainant has a tendency to make allegations of a sexual nature against others. Thirdly, something disclosed during the course of a private and confidential therapy session may be used against the complainant, which is problematic. Therapeutic discussion and legal testimony have contrasting objectives. A therapist is less concerned with facts and details than a criminal court or a cross-examining counsel. The focus and purpose of a counselling session is the complainant's state of mind, emotions and any feelings of distress. For this reason, therapeutic discussion should not be regarded as a reliable record of the factual matters in issue at trial, which is to say, it is not an accurate account of what happened.

A further consequence is that this practice may make complainants reluctant to seek therapy until their trial has ended, for fear of having personal information disclosed to the court. This fear is a factor which reduces willingness to engage with the criminal justice process. This is symptomatic of a wider reluctance to engage with the criminal justice process in rape complainants with or without mental health issues, an issue which will be considered in detail below.

www.theadvocatesgateway.org/images/toolkits/10-identifying-vulnerability-in-witnesses-and-parties-and-making-adjustments-2017.pdf [accessed Apr 2017].

⁵⁶⁵ This was discussed in chapter one. See also: K Breitenbecher, 'Sexual Revictimization among Women: A Review of the Literature Focusing on Empirical Investigations' (2001) 6 *Aggression and Violent Behaviour* 415; S Sorenson et al, 'Repeated Sexual Victimization' (1991) 6 *Violence and Victims* 299; J Noll, et al, 'Revictimisation and Self-Harm in Females who Experienced Childhood Sexual Abuse: Results from a Prospective Study' (2003) 18 *Journal of Interpersonal Violence* 1452; C Gidycz et al., 'Sexual Assault Experience in Adulthood and Prior Victimization Experiences: A Prospective Analysis' (1993) 17 *Psychology of Women Quarterly* 151.

Part I

The Complainant's mental health: what is the nature and relevance of the material?

As established in Chapter 1, this thesis has used the terms 'mental health' and 'mental health issue' to encompass a broad spectrum of mental health conditions, illnesses, and experiences. This broad spectrum also applies to the nature of the mental health material which the defence may seek access to via pre-trial disclosure or admission at trial. This can include medical records, psychological or psychiatric reports, and records held by local authorities such as social services or educational departments. Counselling or therapy notes may concern either pre or post-assault sessions, and statements concerning the complainant's alcohol or drug intake may also be sought.⁵⁶⁶ However, the relevance of this material to the alleged offence is not always obvious.

Complainants may also generate their own confidential records following an assault if they obtain professional counselling or support from organisations such as Victim Support or Rape Crisis England and Wales.⁵⁶⁷ As discussed in chapter 3, SARC offer a series of counselling sessions to those complainants who attend the centre. These records may be eligible for disclosure, even if they are not created as a formal evidential record. If the complainant receives counselling, both the fact of that counselling and any counsellor notes may be subject to disclosure.⁵⁶⁸ A further category of material is that which was created by the complainant prior to the alleged

⁵⁶⁶ Other material such as telephone records, social media communications between the complainant and accused and CCTV footage are all classifiable as third party material. Such forms of information are not examined as part of this chapter.

⁵⁶⁷ The websites for both of these charities states that they offer counselling but do not give any information about confidentiality or consequences of seeking therapy at trial in regards to disclosure.

⁵⁶⁸ F Raitt, 'Disclosure of Records and Privacy Rights in Rape Cases' (2011) 15(1) *The Edinburgh Law Review* 33, 47-8. This process was discussed in detail in chapter five.

offence. ‘Extensively documented complainants’⁵⁶⁹, for example those who have a history of childhood sexual abuse, or who have experienced domestic violence, often have very comprehensive set of records which relate directly or indirectly to mental health.

Perhaps problematically, even if it does not directly relate to the alleged crime, this mental health material can all be deemed relevant to the credibility and reliability of a complainant. It is often adduced in relation to a complainant’s inability to perceive and recall events, previous complaints, and the defendant’s belief in consent. Each of these is now explored in closer detail.

Complainant suffers from mental health condition making her a less reliable witness

The starting point for a prosecutor in a rape offence should be that a complainant is credible and reliable.⁵⁷⁰ Despite a perception otherwise, a mental health condition does not automatically preclude the giving of reliable evidence. To cite a Mind report, ‘crucially, mental distress is distinct from mental capacity and a link between the two should never be assumed.’⁵⁷¹ For many conditions, there is a need to protect the complainant from additional stress and provide support to enable her to give reliable evidence because the ‘recall of traumatic events can cause significant distress, and recognition of the mental state of the witness and its effect on their

⁵⁶⁹ *ibid* 45.

⁵⁷⁰ CPS, Victims and witnesses who have mental health issues and/or learning disabilities: Prosecution Guidance, ‘Credibility and reliability’ (2010) <[cps.gov.uk/legal/v to z/victims and witnesses who have mental health issues and or learning disabilities - prosecution guidance](http://cps.gov.uk/legal/v%20to%20z/victims%20and%20witnesses%20who%20have%20mental%20health%20issues%20and%20or%20learning%20disabilities%20-%20prosecution%20guidance/)> [accessed July 2016].

⁵⁷¹ Mind, Achieving Justice for Victims and Witnesses with Mental Distress (Mind, 2010) <www.cps.gov.uk/publications/docs/mind_toolkit_for_prosecutors_and_advocates.pdf > accessed July 2016.

behaviour is crucial'.⁵⁷² It is also important to distinguish between four separate attributes of the complainant: credibility, competence, capacity and reliability. They are all factors which affect the perceived or actual quality of the complainant evidence and accounted for by CPS policy in this area. *Victims and witnesses who have mental health issues and/or learning disabilities: Prosecution Guidance* provides that: credibility concerns whether or not the complainant's testimony is *believable*, whereas reliability concerns whether the testimony is *consistent*.⁵⁷³ Competence is a question of whether the witness is able to *understand questions and be understood*.⁵⁷⁴ Capacity involves whether the witness has the ability to *make decisions in their own best interests*.⁵⁷⁵

These four attributes of the complainant can be called into question by mental health issues: first, where the complainant suffers from a pre-existing mental health condition (i.e. the condition existed prior to and is unrelated to the offence). Second, where there is a correlation between having been the victim of a sexual offence/rape and the emergence of a mental health condition in the complainant.

Pre-existing mental health conditions

Evidence of psychiatric disorders or mental health conditions can be deemed relevant because, it is argued, they can affect the complainant's perception or recollection of the offence. In this case, issues of mental health speak to reliability. Material may be deployed to show the complainant is prone to fabrication, which, ipso facto, undermines the credibility of a witness. As discussed in Chapter 2,

⁵⁷² Ministry of Justice, *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses and Using Special Measures* (2011) para [2.73].

⁵⁷³ CPS, *Victims and witnesses who have mental health issues and/or learning disabilities: Prosecution Guidance, 'Credibility and reliability'* (2010)

www.cps.gov.uk/legal/v_to_z/victims_and_witnesses_who_have_mental_health_issues_and_or_learning_disabilities_-_prosecution_guidance/ [accessed July 2016]

⁵⁷⁴ Section 53 YJCEA 1999.

⁵⁷⁵ Mental Capacity Act 2005.

despite evidence to the contrary, an historical association of psychiatric evidence with false complaints is still prevalent, and particularly problematic because it is underpinned by (and perpetuates) a sexist stereotype: the mentally unstable female complainant who is prone to fabrication or is unable to accurately perceive and recall the event in question.

In order to examine the argument that psychiatric disorders or certain mental health conditions have affected a complainant's perception and memory, medical records are sought by the defence. A complainant's version of events can be called into question if it can be shown to the jury that a mental disorder may have caused the complainant to lose 'touch with reality' and therefore they cannot be trusted to speak the 'truth'.⁵⁷⁶ An example of this misconception, and the unfairness it can produce, is illustrated in *R (on the application of B) v DPP*.⁵⁷⁷ In this case, FB had been a victim of an assault. The CPS dropped the case on the grounds that he had schizophrenia and was therefore an unreliable witness. That decision relied on a condition-based assessment and expert evidence which generalised about the impact of schizophrenia on FB's 'reliability as a witness of the truth'.⁵⁷⁸ The Court, however, held that the decision of the CPS not to prosecute this case – on the basis the victim was not reliable or credible – was both irrational and a misapplication of the *Code for Crown Prosecutors*. The judge stated:

The conclusion that [FB] could not be put forward as a credible witness, despite the apparent factual credibility of his account, suggests either a misreading of the doctor's report (as though it had said that FB was

⁵⁷⁶ S Bronitt and B McSherry, 'The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the "rape shield"?' (1997) 8(2) Criminal Law Forum 259, 262.

⁵⁷⁷ (2009) EWHC 106 (Admin).

⁵⁷⁸ Para [19] (Toulson LJ).

incapable of being regarded as a credible witness) or an unfounded stereotyping of FB as someone who was not to be regarded as credible on any matter because of his history of mental health problems.⁵⁷⁹

This case completely disavows the perceived link between a mental health condition and reliability. Nevertheless, mental health evidence, particularly of those psychiatric or mental disorders which can distort the complainant's perception of reality, may still be and is often adduced at trial. The complainant may still be and is often portrayed as 'as a fantasist or a disturbed individual whose allegation is the product of an unbalanced mind, and on this basis, questions her about her mental health in court'.⁵⁸⁰

Although the data regarding individual mental health disorders and effects on attrition rates is limited, it is possible to see that a broad spectrum of mental health conditions, ranging from severe disorders – such as schizophrenia or bipolar – to less severe or more common issues such as depression and post-traumatic stress have been employed to discredit complainant's accounts. According to The Mental Health Foundation, mixed anxiety and depression is the most common mental disorder in Britain.⁵⁸¹ These 'less severe' mental health issues have also been covered in the literature. Ellison discusses the characteristics of depression, noting that a complainant may experience some but not all of these attributes, and that they ought not to affect the complainant's ability to remember events or recount testimony in a truthful way.⁵⁸² This is supported by Mind who explain that:

⁵⁷⁹ Para [55] (Toulson LJ).

⁵⁸⁰ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) E&P 28, 32.

⁵⁸² D Englert, A Diserio and K Ryan, 'The Prosecutor's Guide to Mental Health Disorders' (2007) 1 *The Voice* –American Prosecutors Research Institute Newsletter 1, cited in L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) E&P 28, 33.

Difficulty in remembering things is a symptom associated with depression. Memory can also be affected by some types of medication. Memory problems can become more acute when people feel under pressure or anxious and may affect the consistency of testimony. But there is a difference between recalling details and the underlying reliability of an account. For example, people may have difficulty remembering precise dates and times, but this does not necessarily call the whole account into question. Memory problems may just affect the level of detail or precision, not the reliability or credibility of the testimony as a whole.⁵⁸³

Given this, it might be posited that the true purpose of questioning of a complainant or adducing evidence about a history of mental health issues is to depict that complainant in a negative way. To play upon prejudice surrounding the ‘emotionally unstable’, and even to use that prejudice to suggest motive to fabricate an allegation.⁵⁸⁴ The defence seeks to adduce evidence of other mental health conditions to discredit the complainant; to imply that she is somehow less than ‘trustworthy’. It is the inference which is sought that is problematic. This practice is illustrated in *R v H*⁵⁸⁵: the defendant appealed against a conviction and sentence for, *inter alia*, six specimen counts of rape of a child under 13 and three specimen counts of sexual assault of a child under 13. At trial, the defendant sought to rely on the evidence of a retired psychiatrist and psychotherapist (B). B opined that the complainant suffered

⁵⁸³ MIND, ‘Achieving justice for victims and witnesses with mental distress: A mental health toolkit for prosecutors and advocates’, 12 <www.cps.gov.uk/publications/docs/mind_toolkit_for_prosecutors_and_advocates.pdf> accessed July 2016.

⁵⁸⁴ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 E & P 28, 33.

⁵⁸⁵ [2014] EWCA Crim 1555, CA. Although it is in the context of allegations of sexual abuse against a child, whereas this thesis focuses on adult rape complainants, the case is relevant to the thesis due to its discussion of mental health material being employed to discredit the complainant.

from false memory syndrome – that the complainant held a delusional belief as a result of ‘recovered memories’ acquired in the course of therapy, and had filled in gaps in her memory to make a coherent narrative which had informed her allegations about the defendant. According to B, such recovered memories could not be relied on in the absence of independent confirmatory information. But the judge refused to admit this, on the basis that there was no evidence that enabled the jury to find the complainant had ‘recovered’ or ‘retrieved’ memories during her treatment for her mental illness. The judge further held that aspects of the defendant’s conduct constituted aggravating factors, which included the very serious psychological harm caused to the complainant, and the deliberate and cynical decision of the defendant not to allow treatment for a mental health issue, for the purely selfish reason of preventing her from disclosing the abuse. Complainants with mental health issues are often afraid of reporting a rape for fear an attempt will be made to use their mental health against them at trial. Such a fear was well founded in this case — the defendant had even made threats he would use the complainant’s mental ill-health to discredit her.

Self-harm also falls into the category of a less severe/more common pre-existing mental health issue (although again, this condition can also arise as a result of having been a victim of rape) and can be extremely prejudicial to a complainant’s credibility. Self-harm occurs where the individual hurts herself as a way of dealing with difficult feelings, traumatic memories or overwhelming situations and experiences. It can include physically hurting oneself, but also the practice of placing oneself in situations of high risk, or neglecting physical and emotional needs.⁵⁸⁶ In a trial context, Ellison provides an anecdotal example of how this mental health issue

⁵⁸⁶ <www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/#.U49Cy_lIdUS8> accessed June 2016.

has been exploited by defence counsel: a complainant was asked during cross-examination about her motivations for self-harming – ‘have you ever hurt yourself for attention?’ The defence’s tactic here attempts to provide jurors with an explanation as to why a complainant might not only fabricate an allegation of rape – therefore placing herself at the centre of attention of the ensuing criminal justice process – but potentially also why she would subject herself to a demeaning (and in this instance, violent) sexual encounter. This case is particularly illustrative of the subtle influence that mental health issues can have on attrition rates; the questioning is not a direct attack on the complainant’s credibility: ‘No explicit claims are advanced regarding the complainant’s credibility, yet through innuendo and insinuation the complainant’s mental stability and by extension her reliability are brought into question by the defence.’⁵⁸⁷

Mental health conditions caused by the offence

Research indicates that rape and sexual assault are particularly detrimental to physical, emotional and mental health, and that this is particularly evidenced in women.⁵⁸⁸ (A vicious corollary, given both the high level of victimisation and entrenched attitudes of disbelief towards female complainants and complainants who present mental health issues.) Rape and other forms of sexual violence have been shown to have an association with an increased risk of ‘maladaptive behaviours’ such as problem drinking, substance abuse and illegal drug use.⁵⁸⁹ Research by Boudreaux et al. also found that sexual assault was more strongly related to Post-Traumatic Stress Disorder (PTSD) and depression than to other types of

⁵⁸⁷ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) E&P 28, 34.

⁵⁸⁸ C Kaukinen et al, ‘Sexual assault and current mental health: the role of help seeking and police response (2009) 15(11) Violence against Women 1331-1357.

⁵⁸⁹ C Kaukinen, ‘Adolescent victimization and problem drinking’ (2002) 17 Violence and Victims 669-689; C Kaukinen and A DeMaris, ‘Age at first sexual assault and current substance use and depression’ (2005) 20 Journal of Interpersonal Violence 1244-270.

victimisation.⁵⁹⁰ The results of their research indicated victims of a sexual offence were more likely than non-victims to suffer from PTSD, obsessive-compulsive disorder, agoraphobia, and social phobias. Rape was strongly related to *almost every disorder assessed*, whereas crimes like robbery and burglary were not related to any mental disorder.⁵⁹¹

Trauma is an adaptive response to a threat which causes the individual to react ‘on the arousal continuum from vigilance through to terror.’⁵⁹² As examined in Chapter 4 PTSD involves a range of psychological symptoms that an individual experiences following a traumatic event, such as rape, which is outside the boundaries of normal experience.⁵⁹³ This is normally a delayed response as trauma can induce a sense of detachment from reality and dissociation. As the traumatic event ends, the mind and body slowly move back down the arousal or dissociative continuum. If these symptoms persist then the level of residual trauma may constitute PTSD.⁵⁹⁴ Characteristics of this disorder include re-living aspects of the trauma, intrusive thoughts and images, nightmares, intense distress at real or symbolic reminders of the trauma, avoidance behaviour, emotional numbing, hyper-vigilance and vivid flashbacks which are neither hallucinations nor delusions.⁵⁹⁵ This means that:

[t]he witness may have given a credible and reliable account of the incident when they reported it, but the trauma of the experience could exacerbate their

⁵⁹⁰ E Boudreaux, D G Kilpatrick, H S Resnick, C L Best and B E Saunders, ‘Criminal victimization, posttraumatic stress disorder, and comorbid psychopathology among a community sample of women’ (1998) 11 *Journal of Traumatic Stress* 665-678.

⁵⁹¹ *Ibid.*

⁵⁹² B Perry, *The Effect of Trauma on Children* (2003), <www.childtrauma.org> accessed July 2016.

⁵⁹³ J Herman, *Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror* (Basic Books 1997).

⁵⁹⁴ Advocacy Training Council, ‘Working with Traumatized Witnesses, Defendants and Parties (Toolkit 18: July 2015, The Advocates Gateway) <www.theadvocatesgateway.org/images/toolkit18workingwithtraumatizedwitnessesdefendantsandpartiesjuly2015.pdf> accessed July 2016.

⁵⁹⁵ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 *E & P* 28, 35.

mental distress and affect their testimony at a later stage. Post-traumatic stress disorder can occur months after an event and may result in repression of associated memories, creating difficulty in recalling and recounting the experience consistently. This should not, however, undermine the credibility and reliability of the evidence as a whole and, where necessary, expert evidence should be obtained to account for reasons for inconsistency.⁵⁹⁶

Defence counsel have used the existence of trauma arising of childhood sexual abuse or a previous rape to cast doubt on complainant credibility (although it should be acknowledged that the prosecution may also use past traumas in argument, particularly to explain a delay in reporting of an allegation).⁵⁹⁷ Wilkinson-Ryan provides an anecdotal example of one defence counsel who proposed that flashbacks to a previous sexual assault could have caused ‘confusion’ between consensual sexual intercourse and rape on the occasion in question.⁵⁹⁸ The assumption underpinning this type of strategy is that witness credibility is eroded when a complainant has been raped more than once. Unfortunately, as this thesis has highlighted, there is substantial evidence which indicates that complainants with a history of childhood sexual abuse or adult sexual assault are at an increased risk of victimisation.⁵⁹⁹ It is therefore particularly unfair that repeat victimisation is

⁵⁹⁶ Mind, ‘Achieving Justice for Victims and Witnesses with Mental Distress: A Mental Health Toolkit for Prosecutors and Advocates’, 17
<www.cps.gov.uk/publications/docs/mind_toolkit_for_prosecutors_and_advocates.pdf> accessed July 2016.

⁵⁹⁷ See generally P Lewis, *Delayed Prosecution for Childhood Sexual Abuse* (OUP 2006); A Laurence, M Kebbel, P Lewis, ‘Considerations for experts in assessing the credibility of recovered memories of child sexual abuse: The importance of maintaining a case-specific focus’ (2006) 12(4) *Psychology, Public Policy, and Law* 419-441

⁵⁹⁸ T Wilkinson-Ryan, ‘Admitting Mental Health Evidence to Impeach the Credibility of a Sexual Assault Complainant’ (2005) 153 *University of Pennsylvania Law Review* 1373.

⁵⁹⁹ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 *E & P* 28, 35-6.

perceived as evidence of falsity or of a ‘mentally unstable’ complainant, which in turn is viewed as non-credible.⁶⁰⁰

The above discussion illustrates the ways in which mental health conditions can be used by defence counsel at trial stage to undermine complainant credibility; it is argued that how this impacts on jury perceptions of the complainant’s testimony and her version of the events in dispute can be seen in the high rate of attrition associated with this offence. In adducing evidence of mental health issues, defence lawyers seek to trade on and in fact perpetuate attitudes around mental health – that complainants exhibiting these symptoms or conditions are ‘unreliable, unstable, incredible and liable to make false claims.’⁶⁰¹ This approach is based on the very tenuous assumption that those who receive psychiatric treatment or suffer from mental health conditions are predisposed to make false allegations for various reasons, or are otherwise lacking in credibility. And while it is true that certain conditions, such as schizophrenia, may disclose a tendency to confuse fantasy and reality, however, ‘it is simply erroneous to suggest that mental illness per se impairs a person’s ability to differentiate between the two.’⁶⁰² This thesis therefore contends it has been strongly shown, in research, in practice and under law that using pre-existing mental health issues to discredit a complainant is nearly, if not actually, untenable as a line of defence. And yet the practice persists. It may be advisable to draw a straight bow between the incidence of all these defence tactics in rape cases. Despite the fact they have been disproven, to have any direct bearing on the quality of the complainant’s evidence, not only are they still in use, suggesting the defence are playing to prejudices, and the attrition rate is sometimes due to unfair discrimination.

⁶⁰⁰ *ibid* 36.

⁶⁰¹ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 *E & P* 28, 34.

⁶⁰² *ibid* 32.

The defence may also argue that mental health materials such as therapy notes or medical records are relevant because they may contain details of previous allegations of abuse and/or proof of prior abuse. Defence applications of this nature are likely to occur where the accused and the complainant already know each other or have been in a relationship, as a result of which the accused will be familiar with the complainant's medical and psychiatric history and aware of the existence of such records or material.⁶⁰³ Raitt and Zeedyk propose that if s a record of a previous but *unproven* allegation exists, this may also be adduced to demonstrate a propensity to fabricate allegations of a sexual nature. As touched on in the previous section, even if previous abuse *is* proven this can be used to demonstrate an increased likelihood to fabricate an allegation. In either context, the complainant's credibility can be severely damaged: the complainant is either mistaken or mendacious. Either way, the complainant is presented to the court as unreliable.⁶⁰⁴

Counselling records relevant to the issue of consent

Mental health evidence is also presented as relevant to consent. A complainant's counselling or therapy notes might be argued to possibly contain an admission of or concession to the defendant's reasonable belief in consent. Such an argument will now be considered in greater detail.

The facts in issue in a rape trial are determined by the definition and elements of the offence and the defences which may be raised. As previously elaborated, that a complainant consented or that the defendant had a reasonable belief in consent, are

⁶⁰³ K Busby, 'Discriminatory use of personal records in sexual violence cases' (1997) 9 Canadian Journal of Women & the Law 148, 150-151.

⁶⁰⁴ F Raitt and M Zeedyk, 'False Memory Syndrome: Undermining the Credibility of Complainants in Sexual Offences' (2003) 26 International Journal of Law and Psychiatry 453, 467.

both defences.⁶⁰⁵ Bronitt and McSherry indicate counselling records may reveal statements relating to the complainant's sexual past with the accused or mental state during sexual intercourse. For example, during counselling the complainant may discuss her feelings towards the accused and whether she wanted intercourse to take place. These comments could provide examples of conduct or words that, the defence may then argue, led to the defendant believing the complainant was consenting. Bronitt and McSherry note that any statements in which the complainant explores her own feelings of guilt and shame could be used to show that either the complainant really 'wanted' sexual intercourse to occur, and/or her conduct led the accused to mistakenly believe she was consenting.⁶⁰⁶ In this way the complainant's counselling records may be central to the defendant's claim of consent and are also relevant to his mental state, and in particular, the credibility of his claim of reasonable belief in consent.⁶⁰⁷

Impact of therapy and counselling sessions on testimony

Guidance issued from the General Medical Council states if a doctor or psychiatrist receives a request for access to medical records or counselling notes, then legal advice should be sought.⁶⁰⁸ If a doctor declines the application to view the records and the CPS issues a witness summons, the doctor is entitled to oppose the application. This is because in the medical and psychological fields there is an expectation of confidentiality; it is an integral part of the medical and therapeutic process.

⁶⁰⁵ s1(1) Sexual Offences Act 2003.

⁶⁰⁶ S Bronitt and B McSherry, 'The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the "rape shield"?' (1997) 8(2) Criminal Law Forum 259, 264.

⁶⁰⁷ *ibid* 280.

⁶⁰⁸ General Medical Council, 'Confidentiality: Guidance for Doctors' (October 2009) <www.gmc-uk.org/static/documents/content/Confidentiality_core_2009.pdf> [accessed August 2016.]

Doctors ought to breach confidentiality only in compliance with a court order.⁶⁰⁹ Therapists should be aware of pending criminal proceedings. The CPS must be informed that therapy is taking place and must obtain an assurance from the complainant that she did not say anything inconsistent with what was said to the police.⁶¹⁰ Therapists should avoid leading questions or discussing evidence in detail or exploring the substance of the allegations, because any detailed recounting or re-enactment could be perceived as witness coaching and may lead to a failure or collapse of the case.⁶¹¹

The CPS does identify rape cases where the provision of pre-trial therapy might have some material impact on the complainant's evidence and will assess the consequences of such therapy on the potential success of a trial.⁶¹² There is no available data that shows details of when or how often the CPS halts a case in these circumstances (reporting of attrition at this point often states only 'victim issues'), but, according to prosecutorial policy, the emotional health and well-being of the complainant is meant to be put above all else.⁶¹³ A conflict does arise from that policy – while a vulnerable victim may urgently require treatment or support in the form of therapy, it may be better overall for the complainant if that therapy is delayed until after the trial. Section 28 of the YJCEA 1999 seeks to alleviate that

⁶⁰⁹ General Medical Council, *Confidentiality: good practice in handling patient information* (Jan 2017) 16 <www.gmc-uk.org/Confidentiality2017.pdf 69037815.pdf [accessed Apr 2017].

⁶¹⁰ CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance'.

⁶¹¹ CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance'. Doctors would be aware of this issue as part of best practice/good medical practice.

⁶¹² CPS data on attrition does not provide the specifics of why the case was stopped. The VAGW report lists "victim issues" as one reason for the case discontinuing.

⁶¹³ CPS, 'Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance'.

conflict by allowing for pre-recorded cross-examination to take place.⁶¹⁴ This section is due to be implemented in November 2017.⁶¹⁵ This will mean that the complainant can receive therapy or counselling following a rape and discuss the offence in detail without legal ramifications, as she will have completed giving evidence in court.

Certain forms of therapy are more likely to be prejudicial to evidence. The nature of therapy for this type of victimisation means that it often touches on areas which overlap with witness testimony. Perhaps the least problematic aspect of therapy, in an evidentiary sense, concentrates on improving self-esteem and self-confidence, often using cognitive or behavioural techniques.⁶¹⁶ Leading questions can suggest to the complainant a particular answer; which could be extremely problematic if a complainant adopts that statement as the truth, and state this at trial in her capacity as a witness. At trial propositional style or suggestive questions are only allowed during cross-examination. Discussing the evidence that the complainant will give in court ought also to be avoided and this includes exploring in detail the substance of the specific allegations made.⁶¹⁷ Although the complainant may derive significant therapeutic benefits from talking about her experiences, any detailed recounting or re-enactment of the offending behaviour may be perceived as coaching.⁶¹⁸ Because therapy is a form of ‘pre-trial discussion’ it is therefore subject to apprehension of witness coaching. A detailed therapeutic discussion may potentially lead to the

⁶¹⁴ M Stevenson and H Valley, ‘Pre-Recorded Cross-Examination’, *Criminal Law and Justice Weekly*, 23 May 2014 <www.criminallawandjustice.co.uk/features/Pre-recorded-Cross-Examination> accessed August 2016.

Although this provision has not yet been implemented, a pilot scheme was undertaken in three Crown Courts in England, Wales, Leeds, Liverpool and Kingston-upon-Thames and held to be a success. It is reported that s28 will be rolled out for s16 (age and incapacity) witnesses by November 2017 and s17 (fear and distress) witnesses by November 2018.

⁶¹⁵ HHJ S Drew QC and L Gibbs, ‘A United Approach’, *Counsel Magazine* (March 2017) www.counselmagazine.co.uk/articles/united-approach [accessed Apr 2017]

⁶¹⁶ CPS, ‘Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance’ at [6.2]-[6.4].

⁶¹⁷ *Ibid* [11.9].

⁶¹⁸ *R v Momodou and Limani* [2005] EWCA Crim 177 is the leading case establishing the prohibition against witness coaching in England and Wales.

complainant giving inconsistent accounts of the events in issue and may lead to deliberate or inadvertent fabrication.⁶¹⁹ The prosecution is almost certain to fail as a consequence of this type of therapeutic work.⁶²⁰

Problems may arise during therapy when the therapist attempts to distinguish fantasy from reality in the responses made by the complainant. In this instance, the therapist should be as open to the idea that the material presented as factual truth may be a distortion (even if ‘real’ and meaningful to the witness), as they are to a fantasy being a representation of reality.⁶²¹ But the defence may seek to use this to establish that the allegation of rape is a fabrication. Rather than suggest fantasy or vindictive mendacity on the part of the complainant, the defence may attempt to undermine the complainant’s credibility on the basis that her memory has been distorted or falsified by the therapeutic practice itself.⁶²²

Therapeutic approaches that present the greatest problems in terms of evidential reliability include hypnotherapy, psychodrama, regression techniques and unstructured groups.⁶²³ The CPS discourage any form of group therapy taking place before trial. The danger of this form of therapy is that the complainant may – or the defence may argue – adopt the experiences of others taking part in the therapy. The argument being that this may result in inadvertent or deliberate fabrication; the memory of the complainant and therefore the account given at trial has been influenced by other individuals.⁶²⁴ A complainant may become aware of gaps or

⁶¹⁹ CPS, ‘Provision of Therapy for Vulnerable or Intimidated Adult Witnesses Prior to a Criminal Trial – Practice Guidance’ (Implementing the Speaking up for Justice Report) <www.cps.gov.uk/publications/prosecution/pretrialadult.html> [accessed August 2016].

⁶²⁰ Ibid [11.11].

⁶²¹ Ibid [10.1]

⁶²² S Bronitt and B McSherry, ‘The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the “rape shield”?’ (1997) 8(2) Criminal Law Forum 259, 264.

⁶²³ CPS, ‘Provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial – Practice Guidance’, para [10.4]

⁶²⁴ Ibid [11.10].

inconsistencies in her evidence, particularly when compared with that of others, and seek to ‘fill’ them.⁶²⁵ Whatsoever the outcome, if the complainant takes part in group therapy, and particularly with other rape victims, it is highly likely that her evidence will be viewed as contaminated.

Part II

Consequences of use of mental health evidence

The first part of this chapter has examined the relationship between mental health and rape complainants and considered this issue in the context of the perceived relevance of this information. The second and final part of the chapter sets out the negative consequences of adducing evidence relating to the complainant’s mental health at trial. It considers how the evidence may be liable to misinterpretation by the jury and increases a complainant’s fear of having private information disclosed in court. It examines how this can affect the attrition rate and how the issue of mental health in this area ought to be viewed as a vulnerability rather than undermining the complainant’s credibility.

Humiliation at trial – privacy of complainants

The deterrence to reporting offences caused by the prospect of disclosing (and being questioned or discredited on the basis of) mental health issues⁶²⁶, is analogous to the way in which the admissibility of sexual history evidence at trial prevents complainants from coming forward. Ellison notes:

If the case reaches court there is the personal cost to complainants who may endure an intrusive and humiliating cross-examination where their

⁶²⁵ Ibid [3.3].

⁶²⁶ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 E & P 28, 36.

psychiatric history is not only made public but is used to damning effect against them. For victims of rape, the experience of testifying can be traumatic and is commonly characterised as ‘re-victimisation’. The admission of the complainant’s psychiatric history can only compound the stress of giving evidence, increasing the risk of further traumatisation.⁶²⁷

This fear of not disbelieved, or of attacks on credibility during cross-examination, is a renowned deterrent to those considering reporting a sexual assault,⁶²⁸ but it is also arguable that compelled production of personal information may also deter complainants from seeking necessary treatment. Temkin notes the therapeutic work of those who provide services and assistance to complainants is detrimentally affected by the compelled production of records.⁶²⁹ Society therefore has an interest in facilitating and encouraging therapeutic work that remains private and confidential,⁶³⁰ not least because, as discussed above, threat of disclosure can force complainants to choose between counselling *or* the criminal justice process.⁶³¹ There are significant dangers associated with mental health records disclosure, including the danger jurors will accord it exaggerated significance. Jurors may also dismiss a witness’s testimony due to prejudiced attitudes that research suggests continue to surround mental illness. Furthermore, there is the potential invasion of a complainant’s right to privacy and attendant risk of causing a complainant – who may already be traumatised – unnecessary humiliation and distress. Finally, there is

⁶²⁷ *ibid* 37.

⁶²⁸ L Regan and L Kelly, Rape: Still a forgotten issue, Briefing Document For Strengthening the Linkages – Consolidating the European Network Project (September 2003) para [3.05] <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.361.6073&rep=rep1&type=pdf>

⁶²⁹ J Temkin, ‘Digging the Dirt: Disclosure of Records in Sexual Assault Cases’ (2002) 61(1) Cambridge LJ 126, 136.

⁶³⁰ *ibid* 131-2.

⁶³¹ *ibid* 132.

the danger of deterring other rape complainants from engaging with the criminal justice system at all.⁶³²

Admission of material maintains an adherence to stereotypes about mental health and rape complainants' mental instability

The disclosure of mental health material suggests a continuing adherence to stereotypes particularly of female instability and mental health – and this in an area which already suffers from a great deal of existing stigma and misconception.⁶³³

Mental health is one of the areas in which society in general has a poor understanding; negative or misinformed views about those with a psychiatric condition are commonplace.⁶³⁴ Ellison states that the many misconceptions of and unfavourable attitudes towards mental health have dangerous implications for a complainant in the trial context. Such personal information has the potential to be highly prejudicial in the context of rape proceedings and may have little connection with the complainant's credibility.⁶³⁵

Preconceptions and negative stereotypes about mental health are widespread, with approximately nine out of ten people with mental health issues experiencing stigma and discrimination.⁶³⁶ The following table sets out some incorrect assumptions about mental health issues; this section will then examine how these common assumptions

⁶³² L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 43.

⁶³³ The topic of mental health stigma was considered in chapter 2.

⁶³⁴ In 1998 the Royal College of Psychiatrists launched a campaign to improve public understanding and reduce the stigma of mental health issues. www.rcpsych.ac.uk/about/campaigns/changingmindscampaign1997-.aspx

⁶³⁵ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 32.

⁶³⁶ Time to Change, Stigma Shout: Service user and carer experiences of stigma and discrimination. Mind and Rethink (2008) www.time-to-change.org.uk/challenging-discrimination/what-discrimination/research accessed July 2016.

can influence perceptions of credibility.⁶³⁷ The table below illustrates how easily information relating to mental health is liable to misinterpretation.

MYTH	FACT
Mental health conditions are very rare.	Mental health conditions affect one in four people. ⁶³⁸
People experiencing mental distress are different from normal people and less able to participate in everyday life.	We all have mental health, like we all have physical health.
People with mental health conditions never recover.	People with mental health conditions can and do recover (also people may also go through stages; mental distress is fluctuating – people may have periods where they experience no symptoms at all).
People with mental health conditions are violent and unpredictable.	Research shows people with mental health conditions 14 times more likely to be a victim of a violent crime than to be arrested for such a crime. ⁶³⁹
People with certain diagnoses, particularly psychotic conditions, can never be relied upon to remember and report events accurately.	There is no known mental health condition which prevents everybody with that condition from accurately remembering and reporting something that has happened.

Table 5: Common Assumptions about Mental Health

Evidence liable to misinterpretation by jury

Raitt discusses how the merest reference to mental illness, even to a condition as common as depression or anxiety, creates disbelief. There may be no factual or

⁶³⁷ Mind, Achieving justice for victims and witnesses with mental distress: A mental health toolkit for prosecutors and advocates (2010) 9
<www.cps.gov.uk/publications/docs/mind_toolkit_for_prosecutors_and_advocates.pdf> accessed July 2016.

⁶³⁸ D Goldberg and P Huxley, *Common Mental Disorders – A Bio-Social Model* (Routledge 1992).

⁶³⁹ E Walsh et al, 'Prevalence of violent victimisation in severe mental illness' (2003) 183 *British Journal of Psychiatry* 233–8.

evidential connection between some forms of mental illness and a complainant's veracity. However, if the defence is given the opportunity to make the suggestion of a connection 'it may be enough to create a misleading doubt in the mind of a juror.'⁶⁴⁰ Any material relating to mental health issues is prejudicial.

In the absence of expert evidence to explain this area of psychiatry, the jury may also be susceptible to unproven but 'superficially attractive inferences' about a complainant's psychological stability.⁶⁴¹ As discussed above, societal and public understanding about mental health issues is extremely poor.⁶⁴² Individual jurors should not be expected to assess what effect, if any, an illness such as depression may have on the credibility or reliability of a witness. Raitt provides an example of the unfair operation of this evidence – that the average juror is unlikely to be able to assess 'the impact of a complainant's referral for counselling for alcohol addiction or depression six years prior to the reported offence; or to assess the probative value of anti-depressant medication prescribed six months prior to the alleged offence'.⁶⁴³ For these reasons, where arguably irrelevant psychiatric evidence is adduced, jurors are invited by defence counsel to draw unwarranted and adverse inferences regarding a rape complainant's credibility. As jurors are likely to attach exaggerated significance to mental health evidence, this is likely to have a distorting influence on juror

⁶⁴⁰ Raitt F, 'Disclosure of Records and Privacy Rights in Rape Cases' (2011) 15(1) *The Edinburgh Law Review* 33, 49.

⁶⁴¹ *ibid* 50.

⁶⁴² In July 2015 The Advocacy Training Council published a toolkit on working with traumatised witnesses and defendants in order to ensure that the system is fair and communication at trial is effective: 'Working with traumatised witnesses, defendants and parties Toolkit 18' (The Advocates Gateway July 2015) www.theadvocatesgateway.org/images/toolkit18workingwithtraumatisedwitnessesdefendantsandpartiesjuly2015.pdf accessed July 2016.

⁶⁴³ Raitt F, 'Disclosure of Records and Privacy Rights in Rape Cases' (2011) 15(1) *The Edinburgh Law Review* 33, 50.

decision-making to the prejudice of the complainant and the fact-finding process overall.⁶⁴⁴

The Difference between therapy and criminal proceedings

The content and purpose of therapy sessions and counselling is very different from evidence that is used to prove facts in court – what takes place during a session is liable to misinterpretation when taken out of context. Trial proceedings and a counselling session serve extremely different functions. This chapter finds that using the content of therapy to prove facts in issue is problematic at best.

The relevance of counselling records to the rape trial process is doubtful; the vast majority of information recorded during the session bears no relevance to the disputed issues at trial. The ‘relevance’ of such records must be understood and challenged within the general context of the substantive law of rape. Furthermore, Bronitt and McSherry’s argue that the evidentiary rules are shaped by discriminatory and stereotypical ideas about female sexuality.⁶⁴⁵ This view appears to be in reference to the assumption that women’s allegations of rape are ‘simply confabulation, borne of hysteria, repressed sexuality.’⁶⁴⁶ By enabling access to counselling or medical records, the focus shifts from that analogous sexual history previously discussed, to psychiatric history; both of which perpetuate unwarranted generalisations about *women*, which is to say that women are already subject to societal discrimination based on the prejudiced view that as a gender they are ‘unstable’ and lacking in credibility. The inherent bias around women with mental health issues or female sexual histories are only compounded by that existing

⁶⁴⁴ L Ellison, ‘The Use and Abuse of Psychiatric Evidence in Rape Trials’ (2009) 13 E & P 28, 36.

⁶⁴⁵ S Bronitt and B McSherry, ‘The Use and Abuse of Counselling Records in Sexual Assault Trials: Reconstructing the “rape shield”?’ (1997) 8(2) Criminal Law Forum 259, 263.

⁶⁴⁶ *ibid* 265.

prejudice. The shift from adducing sexual history to psychiatric evidence as a trend in the United Kingdom as discussed at the beginning of the chapter is a worrying reflection of these prejudices; it does not seem coincidental that a defence strategy which attempts to show the complainant is at the very least untrustworthy, and at most not credible, should continue to be a signal defence against complainants who are, in the main, female.⁶⁴⁷

Temkin is also doubtful as to the relevance of counselling records for use at trial. Her argument is that counselling records ought not to be used as an evidential document at trial because, as has been maintained in this thesis, the purpose of their creation does not correspond with how they will be used at trial: they are not legal documents. Rather they are a record of the counsellor's perceptions in combination with therapeutic analysis.⁶⁴⁸ Further, the counsellor's notes are not viewed or checked by the complainant and therefore may be inaccurate as they relate to the events in question.⁶⁴⁹ However, this may be viewed as more of an issue of the weight to be attributed to the evidence rather than relevance.⁶⁵⁰

Rape complainants may blame themselves and express feelings of guilt and shame – which is one reaction that complainants may feel.⁶⁵¹ However, these feelings 'relate to the inner world of the victim and not to the external reality of what occurred. As such, they can only mislead the jury.'⁶⁵²

⁶⁴⁷ Ibid.

⁶⁴⁸ J Temkin, 'Digging the Dirt: Disclosure of Records in Sexual Assault Cases', (2002) 61.1 Cambridge LJ 126, 129-30.

⁶⁴⁹ J Benedet and I Grant, 'Sexual Assault and the Meaning of Power and Authority for Women with Mental Disabilities' (2014) 22(2) Fem Leg Stud 131, 132.

⁶⁵⁰ S Leahy, 'Too much information? Regulating disclosure of complainant's personal records in sexual offence trials' [2016] Crim LR 229.

⁶⁵¹ A Burgess and L Holmstrom, 'Rape Trauma Syndrome' (1974) 131(9) American Journal of Psychiatry 981, 983.

⁶⁵² Ibid.

Goals of therapy versus legal objectives of a criminal trial

Raitt and Zeedyk believe that therapy is not about what happened, per se, rather the focus is the effect of trauma and the meaning the complainant attributes to her thoughts and feelings. The environment is one in which the complainant should feel at ease and free from judgement. This is in complete contrast to the aims of criminal adjudication. Raitt and Zeedyk have noted the professional concern of a therapist or psychiatrist is not to reach for an objective determination of what occurred between the complainant and accused but to understand the meaning that the complainant has ascribed to the event(s). They argue that at the core of the conflict lies a difference in epistemological orientations.

Therapists are not seeking a single objective truth. Memory has value for them, regardless of whether or not it meets the criteria of scientific objectivity, because the primary goal of therapists is to return patients to good health. They are comfortable with the possibility that there may be two contrasting, but equally valid, perspectives on an event.⁶⁵³

The preference in therapy or counselling is for subjectivity over objectivity and rationalisation, the latter being key concerns of the courtroom. The authors emphasise how this conflict becomes particularly acute when a complainant's memories are subjected to the scrutiny of the courts, whose responsibility is to determine the guilt or innocence of the accused.⁶⁵⁴

⁶⁵³ F Raitt and M Zeedyk, 'False Memory Syndrome: Undermining the Credibility of Complainants in Sexual Offences' (2003) 26 *International Journal of Law and Psychiatry* 453, 462.

⁶⁵⁴ *Ibid* 462.

The above discussion considered how counselling records may be sought by the defence as material for cross-examination on the basis of both relevance to the issue of consent and as part of an attempt to discredit the complainant.

Consent is the most frequent defence adduced at a trial for rape. The argument follows that the complainant is *lying*. The defence will then advance various strategies to attempt to prove this argument, the aim being discrediting the complainant. So a rational fear of disbelief may cause complainants with mental health issues to withdraw their complaint, or deter them from reporting it in the first place. This illustrates the close link that exists between mental health, humiliation/disbelief, and the rate of attrition.

Conclusion

This chapter finds that the admission of material relating to the complainant's mental health can unfairly undermine, or at the very least influence, perceptions of complainant credibility and that such perception is frequently related to misconceptions about mental health. The substantive law permits the defence to make wide claims of relevance with respect to counselling records and that the traditional approach discriminates against rape complainants with mental health issues. In principle, the evidence should not be admitted at trial. However, in light of the prosecution's disclosure obligations under the CPIA 1996, if the defence were to make use of the material at trial, this should be accompanied by a judicial direction as to the need for caution when approaching this information. For example, the extreme variation of the objectives involved in therapy to those of trial and that any evidence produced in therapy should be considered in the therapeutic context in which it was created.

The extent of the damage to credibility can be consequential in that the prosecution is unable to prove the accused's guilt beyond a reasonable doubt. Therefore, credibility is influential on attrition, and mental health issues affect a complainant's credibility.

The mere fact that a complainant has received treatment for a mental illness does not, and should not, constitute sufficient evidence to support a conclusion that she is an unreliable witness. Furthermore, any mental health material is unlikely to be relevant when the mental health condition precedes the events as it has no bearing on the issue of consent or the defendant's belief in consent. The defence counsel may seek access to information about a complainant's mental health or question complainants about this evidence at trial in the hope that 'the merest hint of psychological aberration will be sufficient to discredit their accounts'.⁶⁵⁵ This approach both assumes and engenders a simplistic and flawed understanding of mental illness and the relationship between mental health and complainant credibility.⁶⁵⁶ Information derived from psychiatric or therapeutic interventions is disproportionately prejudicial to complainants because it permits general public ignorance of mental disorder to be conflated with rape myths – for example, the myth that rape complainants are fantasists and prone to fabrication.⁶⁵⁷ Raitt argues that this stereotyping of mental illness reinforces gender inequalities already embedded in rape and sexual assault trials.⁶⁵⁸ These misconceptions have serious implications for the fair administration of justice in rape cases.⁶⁵⁹

⁶⁵⁵ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 32-33.

⁶⁵⁶ *ibid* 36.

⁶⁵⁷ J Temkin, 'Digging the Dirt: Disclosure of Records in Sexual Assault Cases' (2002) 61.1 Cambridge LJ 126.

⁶⁵⁸ F Raitt, 'Disclosure of Records and Privacy Rights in Rape Cases' (2011) 15(1) The Edinburgh Law Review 33, 48-9.

⁶⁵⁹ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 36.

The disclosure obligations placed upon the prosecution are essential to the criminal process and to the accused's right to a fair trial. When conducted properly, all material that is relevant to the outcome of the trial should be placed before the court ('relevant material' being information which may prove or disprove the issues disputed by the prosecution and defence). Difficulties ensue when the evidence is used improperly or is arguably irrelevant. This chapter has shown that the relevance of mental health issues and material is tenuous at best, and damaging at worst. If the value of material relating to the complainant's mental health is only to be found via negative inferences and stereotyping surrounding mental health, which defence counsel then relies upon in order to discredit the complainant before the court, then, this thesis argues, the material should not be considered relevant.

When considering relevance of material relating to the complainant's mental health one must consider the issue to which it is directed at trial. The received view is that a complainant who suffers from a mental health condition is a less reliable, i.e. less accurate, witness. This stems from a presumption that mental health conditions always affect perception and memory, and the generalisation that those with mental health conditions are unable to distinguish fact from fantasy. This is a misconception: many mental disorders, such as depression, do not, or do not substantially, affect the complainant's ability to perceive events. Furthermore, such material is perceived to be relevant where it reveals that the complainant has made previous allegations, the existence of which, the defence will then argue, suggest the complainant is lying about a current allegation.

However, as this chapter has demonstrated, there are substantial problems created by seeking this type of material. Firstly, it relies upon misconceptions surrounding mental health and, particularly women's, psychological stability; such evidence is

liable to be misinterpreted by the jury. Secondly, there is a close correspondence between the rates of attrition and the mental health of rape complainants; those with mental health issues are at a higher risk of victimisation (as compared with the rest of the population), an issue that has been referred to throughout this thesis. They are also less likely to be believed by the police and are thus afraid to submit reports; thus a vulnerable group in society is only further alienated. Thirdly, the relevance of and weight attributable to counselling records is highly questionable – the goals of therapy and the objectives of a criminal trial are very different. For these reasons this chapter finds that the admission of information relating to the complainant's mental health can unfairly undermine perceptions of complainant credibility and consequently unfairly influence the verdict in favour of the defendant.

CHAPTER 7: Conclusions

Summary of Thesis

This thesis has examined the relevance and impact of complainant mental health conditions to the investigation and prosecution of rape allegations, in particular on attrition rates. It considered the relationship between mental health conditions and rape complainants, encompassing both complainants with pre-existing mental health conditions and those who seek counselling or therapy following a rape. Chapter 1 explored in more detail the empirical evidence that rape complainants are often likely to suffer from a mental health condition.⁶⁶⁰ In the following chapters, an explanation of various mental health conditions was given, including bipolar disorder, trauma and PTSD. This was done in order to understand the nature of such conditions and their symptoms to then bring them in relation to the position of a complainant with a mental health issue during the criminal justice process. Different conditions have varying symptoms and will consequently have a different effect on the complainant's credibility. This encompasses how the complainant appears to others, but it can also affect how the complainant provides an account of the offence in the ABE interview, for example, as was discussed in Chapter 4. When looking at the symptoms common to many mental health disorders and comparing them to relevant considerations in a judicial process, e.g. credibility and the complainant's ability to withstand the criminal justice process, it was clear that the mental health condition is likely to have an effect, and that exploration of those effects was warranted.

⁶⁶⁰ B Stanko and E Williams, 'Reviewing Rape and Rape Allegations in London: What are the Vulnerabilities of the Victims who Report to the Police?' in M Horvath and J Brown (eds) *Rape: Challenging Contemporary Thinking* (Willan Publishing 2009).

The thesis has evaluated how the police and the CPS perceive or assess the rape complainant and her account. It also considered how the presence of a mental health issue influences decision-making, specifically, how it affects the decision as to whether the case will progress through the criminal justice process. This decision is closely connected with the rate of attrition – the process by which a case ‘drops out’ of the criminal justice system and does not result in a conviction.⁶⁶¹ There are various exit or attrition points located chronologically at the police investigation, CPS prosecution and trial stages. At these specific stages, decisions are made as to whether to progress the case further. This point – that attrition is high for those rape complainants with mental health problems – formed the basis for the research enquiry in this thesis. Whilst reporting rates for rape are increasing in England and Wales, the conviction rate has not progressed and cases continue to drop out of the system.⁶⁶² Rape cases have a particularly high rate of attrition; between half and two-thirds of reported complaints will be discontinued at an early stage, either through self-withdrawal or through a decision by the police not to continue.⁶⁶³ This means that the attrition rate is at its highest at the early stage of the police investigation. This figure is even higher for complainants with mental health issues,⁶⁶⁴ thus it is

⁶⁶¹ L Kelly, J Lovett and L Regan L, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005) 7.

⁶⁶² S Grace, C Lloyd and L Smith L, *Rape: From Recording to Conviction* (Research and Planning Unit Paper 71, Home Office 1992), J Harris and S Grace, *A Question of Evidence? Investigating and Prosecuting Rape in the 1990s*, (Home Office Research Study 196, 1999), HMCPSI/HMIC, *A Report on the Joint Inspection into the Investigation and Prosecution of Cases Involving Allegations of Rape: a CPSI and HMIC joint thematic inspection* (HMCPSI, April 2002), L Kelly, Lovett J and Regan L, *A Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005), S Lea et al, ‘Attrition of Rape Cases: Developing a Profile and Identifying Relevant Factors’ (2003) 43(3) *Brit J Criminol* 583, V Stern, *A Report by Baroness Vivien Stern CBE of An Independent Review into How Rape Complaints are Handled by Public Authorities in England and Wales* (London: Home Office 2010). For recent figures see, CPS, *Violence against Women and Girls: Crime Report 2013-2014* www.cps.gov.uk/publications/docs/cps_vawg_report_2014.pdf.

⁶⁶³ L Kelly, J Lovett and L Regan A *Gap or a Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293, 2005).

⁶⁶⁴ K Hohl and E Stanko, ‘Complaints of Rape and the Criminal Justice System: Fresh Evidence on the Attrition Problem in England and Wales’ (2015) 12(3) *European Journal of Criminology* 324.

important to investigate how these issues relate to, impact and influence the procedural development of the rape case.

Having this fact in mind, the thesis follows the procedural history of a case, from report to court, and examines specific stages where case progression decisions are made. Key pre-trial stages include the initial reporting of the allegation to the police and attendance at a Sexual Assault Referral Centre (Chapter 3), the complainant's Achieving Best Evidence interview (Chapter 4) with the police and pre-trial disclosure as part of prosecution case building (Chapter 5). Cross-examination or the admission at trial of material relating to the complainant's mental health was a critical trial process that was considered (Chapter 6). The thesis has considered how when the complainant reports the allegation to the police and participates in an ABE interview this is directly correlated to the symptoms of mental health issues and how the complainant appears – thereby influencing how the police perceive the complainant. At later stages of the judicial process, when the allegation has been referred to the CPS, this involves the case building stage and the focus becomes the use that may be made of material relating to the complainant's mental health, whether this is medical records or counselling notes.

This thesis finds that the fact that the complainant has a mental health condition is a common characteristic of a rape complaint and should therefore not be a reason to doubt the veracity of the allegation. The complainant's mental health should not have a prejudicial effect on the complainant's credibility and the progression of the allegation. Instead, this characteristic ought to be viewed as a factor that makes the complainant more likely to be a victim of rape in the first place. Those with mental health issues are at a higher risk of victimisation (as compared with the rest of the

population).⁶⁶⁵ Having a mental health condition is a common vulnerability of a rape complainant yet; often complainants are reluctant to inform police of their mental health condition and the police fail to recognise that mental health is in issue.

Similarly, though this is a common vulnerability, at trial, access to the information concerning the complainant's mental health is commonly sought to discredit her account. This both stems from and feeds into self-sustaining myths and misconceptions surrounding mental health and sexual behaviour. The area relating to a complainant's mental health and the investigation and prosecution of a rape allegation can be confusingly circular at times, i.e. having a mental health condition is usually linked to causal and/or detrimental environmental conditions that in turn place the complainant at a higher risk of victimisation. However, having a mental health issue is simultaneously a factor that can discredit the complainant.

The following sections elaborate further the key conclusions underpin the thesis.

Key Conclusions and Findings

The main findings of the thesis are:

- The treatment of complainants with mental health issues should be individualised
- The initial reporting of the allegation to the police is a critical time
- Trauma can affect the evidential quality of the account obtained during interview

⁶⁶⁵ B Pettitt, S Greenhead, H Khalifeh et al., *At Risk Yet Dismissed: The Criminal Victimisation of People with Mental Health Problems* (London: Victim Support/Mind 2013).

- Whether the case will proceed to trial is dependent on whether the complainant is willing to disclose personal information about her mental health
- There exists a contentious relationship between the right of privacy and disclosure
- Admission of mental health material at trial is problematic

These findings will now be examined in turn.

The treatment of complainants with mental health issues should be individualised

This thesis argues that the issue of mental health is highly individualised, and should be viewed as such within the context of treating complainants of rape. In regards to a specific condition, this is something which is not uniform and many variables exist which determine the nature of the condition as it is experienced by the complainant. Bipolar disorder was employed as an illustrative example of how its symptoms can impact upon the complainant's credibility, the type of account of the offence she provides, and her ability to engage with or withstand the trial process. This illustrates how there are many factors at play which impact case progression decisions and no one factor is singly determinative. Ensuring an individualised approach to mental health may contribute towards the complainant's experience of the early investigative stages.

The initial reporting of the allegation to the police is a critical time

Chapter 3 outlined the process of reporting a rape allegation to the police and details the relevant procedures. In England and Wales, there is legislation and guidelines which deem a complainant to be vulnerable if they have a mental health condition.

The chapter considered the earliest investigative stage of the criminal justice process and focused on the burden on and the failure by, police to identify that vulnerability. It was discussed how vulnerable complainants, specifically those with mental health conditions, can present challenges at this preliminary stage, both for the police, in terms of identifying that the complainant has mental health issues, and for the complainant, in regard to whether they inform the police of this fact.

Police treatment of rape complainants at the initial reporting is important and needs to be improved. This initial investigative stage is critical because it affects the complainant's involvement with the criminal justice system and is influential in shaping how the case and the complainant is presented at trial. The complainant's decision to make a report to the police is merely the first step within the criminal justice process and one of the only steps (excluding a decision to withdraw) that the complainant takes herself.⁶⁶⁶ For rape complainants generally there are a number of barriers in regard to reporting the allegation, such as a fear of not being believed by the police and of the trial process. However, further obstacles are presented for complainants with mental health issues. The thesis considered the general societal stigma associated with mental health. This attitude may be one factor which influences the complainant's decision to inform the police or the CPS of her condition due to the (perceived) shame associated with having a mental health condition.

Respect for and sensitive treatment of the complainant is of particular importance at this stage of the investigation because of the high number of complainant withdrawal at this point. Some of the concerns regarding police treatment of complainants with

⁶⁶⁶ C Hanly, D Healy and S Scriver, *Rape and Justice in Ireland: A National Study of Survivor, Prosecutor and Court Responses to Rape* (Liffey Press 2009) 47.

mental health issues relate to a lack of training and awareness in this area. Kelly et al. acknowledge that ‘a culture of suspicion remains within the police’ and consequently ‘this reproduces an investigative culture in which elements that might permit a designation of a false complaint are emphasised.’⁶⁶⁷ Once the allegation of rape is reported, the complainant’s role is reduced to that of a witness and it is the police and CPS who take responsibility for the progression or discontinuance of the case.⁶⁶⁸ Ellison et al., have also noticed how this can generate difficulties for all rape complainants, particularly where they are inadequately supported as vulnerable witnesses, potentially left out of communications about the progression of their case or ‘dropped’ from the system as a result of others’ decision-making.⁶⁶⁹

Within the criminal justice system in England and Wales, evidence exists of prejudicial attitudes regarding mental health and shows that some decisions of the police regarding case progression were based on an incorrect understanding of mental health problems.⁶⁷⁰ This has the potential to result in negative justice outcomes for complainants with mental health issues.⁶⁷¹ Some complainants have expressed a perception of prejudicial attitudes existing within the police service and felt concern about not having been believed or taken seriously as a witness because of their mental health status.⁶⁷² Such reports tally with similar comments from those working in mental health support. For example, in Mind’s 2007 survey 64 out of 73 support workers said people with mental distress being seen as unreliable witnesses

⁶⁶⁷ L Kelly, J Lovett and L Regan, *A Gap or Chasm? Attrition in Reported Rape Cases* (Home Office Research Study 293 2005).

⁶⁶⁸ L Ellison, V Munro, K Hohl, P Wallang, ‘Challenging criminal justice? Psychosocial disability and rape victimisation’ (2014) 15(2) *Criminology & Criminal Justice* 225, 230

⁶⁶⁹ *Ibid.*

⁶⁷⁰ B Pettitt et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013).

⁶⁷¹ Mind, *Silenced Witnesses* (2001), A Watson et al., ‘Officers’ attitudes toward and decisions about persons with mental illness’ (2004) 55(1) *Psychiatric Services* 49.

⁶⁷² B Pettitt B et al., *At Risk, Yet Dismissed: The criminal victimisation of people with mental health problems* (London: Victim Support / Mind, 2013) 9.

was a problem. This has repercussions for rape complainants with mental health issues and therefore it may be less likely for the case to be pursued through the criminal justice system and result in a conviction.

A further problem in this area is that police are unable to identify or sometimes fail to see that the complainant has a mental health issue. This is a problem because the complainant may need different treatment and their condition can affect the initial quality of the account given to police and their behaviour. The police need to be able to identify that the complainant has a mental health condition in order to make necessary adjustments.

An important suggested reform in this area is the provision of education and training to police regarding mental health. Training is important because it gives police officers knowledge in order to understand the needs of complainants with mental health problems and how to offer support. A failure to recognise and properly respond to the complainant's mental health can affect whether or not the case progresses through the criminal justice system. However, this will have to recognise the previous finding that mental health is highly individualised and can have many symptoms. It would be overly ambitious to expect that police officers, otherwise lay persons, would have the appropriate level of education and training to be able to recognise the range of symptoms associated with different mental health issues. Nonetheless, the provision of adequate training will equip police officers with the necessary ability to recognise a potential mental health issue in the first place, and to seek further advice and support by a professional psychiatric/medical professional.

In terms of providing practical or emotional support to complainants with mental health issues, many of the obstacles seem to derive from failures of implementation

rather than from an absence of policies or examples of best practice.⁶⁷³ Whilst this possibility is recognised, I still believe in some respects there is inadequate training. Specifically, this concerns the ability to recognise the mental health issue in the first place. It seems that effectively assessing complainant vulnerability as it relates to mental health at the beginning of the criminal justice process remains problematic. Although there are better processes for early identification of mental health conditions and guidelines to increase awareness of how disclosures can be made, there will be time before we can observe the positive effects of these changes.

Trauma can affect the evidential quality of the account obtained during interview

Chapter 4 examined the complainant's interview with police and discussed how a traumatised complainant will be affected in her account to police. The quality of the complainant's account of events is influential, if not determinative, of whether the case for the prosecution proceeds to trial and a conviction for rape secured.⁶⁷⁴

This chapter focused on the police interview and analysed the barriers to producing a credible account, specifically where the complainant is traumatised or is suffering from a condition like PTSD. This involved examining the influence of the conditions that affect memory, and how it can affect the account given during interview due to the problems of recall stemming from event. Specifically, the evidential quality of an interview can be influenced by the ability of a traumatised complainant to recall details of the offence and accuracy and consistency may be affected.

⁶⁷³ K Cook, 'Rape Investigation and Prosecution: Stuck in the Mud?' (2011) 17(3) *Journal of Sexual Aggression* 250; J Brown, 'We mind and we care but have things changed? Assessment of Progress in the Reporting, Investigating and Prosecution of Allegations of Rape' (2011) 17(3) *Journal of Sexual Aggression* 263, Home Office, *The Stern Review: A Report by Baroness Vivien Stern CBE of an Independent Review into how Rape Complaints are Handled by Public Authorities in England & Wales* (2010).

⁶⁷⁴ M Kebbell and N Westera, 'Promoting pre-recorded complainant evidence in rape trials: Psychological practice perspectives' (2011) 35 *Crim LJ* 376.

Rape complainants might give accounts of the offence which are inconsistent, missing information or contain discreditable material because they are traumatised or have a mental health condition. Characteristics displayed in interview may undermine credibility in the eyes of police: specifically, the complainant may have inconsistency and incoherence of account. It follows that any evidential weakness in an interview account is liable to undermine complainant credibility. This assessment may in turn affect the decision as to whether the CPS will decide to prosecute or take 'no further action.' Any inconsistencies or omissions in the account or incomplete information increase opportunities for the defence to discredit the complainant during cross-examination at trial.

This has implications for juror assessments on the credibility of the complainant and her allegation. Therefore the relationship between the complainant and the police during interview becomes essential – obtaining a strong statement of high evidential quality is likely to improve the chances of conviction, or at least render the account one which a jury will be willing to believe. The characteristics for measuring the quality of a testimony at trial – accuracy, coherence and completeness – directly relate to a complainant's account to police during interview. To improve the chances of securing a conviction it is essential that rape complainants present accurate, coherent and credible testimony during interview.⁶⁷⁵

Such characteristics can unfairly influence the complainant's credibility if the police do not address these issues properly. As was the case for Chapter 3, the issue appears to be one of education and training and the need to improve police understanding of the effects of rape as it impacts upon the complainant's mental health. Here, the task

⁶⁷⁵ M Kebbell, C O'Kelly and E Gilchrist, 'Rape Victims' Experience of Giving Evidence in English Courts: A Survey (2007) 14(1) *Psychiatry, Psychology & Law* 111.

might be easier as once the complainant is assessed as having a mental health issue, it is probable that trained police officers will be aware of the effects of trauma. However, there still might be problems where complainants have not been assessed as such and thus the police do not consider that the account may be influenced by trauma, or a mental health condition of another kind. Nevertheless, a more cautious approach will not impact the quality of the account. This will be subjected to the cross-examination procedures at trial at any rate.

Whether the case will proceed to trial is dependent on whether the complainant is willing to disclose personal information about her mental health

Chapter 5 set out the means by which personal information about the complainant, including information relating to her mental health (e.g. medical records) and/or any therapy or counselling which has taken place, is disclosed to the defence. It examined the process of the prosecution giving information about the complainant's mental health to the defence. This chapter considered the problems associated with the disclosure process, and is closely associated with chapter 6 that examines the further faith of the disclosed material at trial.

The obligations of disclosure placed on the prosecution mean that they must, prior to trial, provide the defence with any evidence which may undermine the prosecution or assist the defence case.⁶⁷⁶ Such material is defined as 'unused material' that may be relevant to the investigation that has been retained but does not form part of the case for the prosecution against the accused.⁶⁷⁷ Different tests apply regarding material in the possession of the prosecution and material that is in the possession of third parties. The chapter argued that there is critical problem that the prosecution do

⁶⁷⁶ Section 3 Criminal Procedure and Investigations Act 1996 (CPIA 1996).

⁶⁷⁷ CPS 'Disclosure Manual' para [1.6].

not properly consider whether the material should or needs to be disclosed to the defence and the concomitant problems of ‘over-disclosure’. A central concern is that the CPS sometimes adopts an approach whereby material or documents concerning the complainant are disclosed as a matter of course, even where they do not fall to be disclosed under the CPIA 1996. A further problem, identified in the chapter, is that sometimes it is unclear whether consent has been obtained either by the police or by the prosecution defence.⁶⁷⁸ This has serious ramifications for the complainant’s right to privacy, as well as the ability to influence the outcome of the case.

There is an ongoing problem with the process and current prosecutorial practices that if the complainant refuses defence or prosecution access to certain material, the CPS may discontinue to the case. This relates to a wider problem concerning the CPS decision to progress the case and therefore the way in which mental health impacts upon case attrition. The findings pinpoint that the management of the disclosure process is a crucial problem for attrition particularly for the reasons of type of material that is disclosed, despite any potential objections by the complainant. There are negative inferences and stereotyping surrounding mental health that defence counsel then rely upon in order to discredit the complainant in the eyes of the court, and the ways in which disclosure is managed, with a clear disregard of the complainant’s wishes, contributes to this prejudice. To remedy this, the prosecution need to ensure that they adhere to their disclosure obligations under the CPIA 1996, apply the test properly and seek to access only material that has a relevant bearing on the issues in the case.

The contentious nature of the relationship between the right of privacy and disclosure

⁶⁷⁸ HMCPSI, *Disclosure of Medical Records and Counselling Notes* (July 2013).

The management of the disclosure regime is fraught with the potential problems of conflict between the right of the accused to a fair trial and the complainant's right to privacy. This has a crucial bearing upon attrition since the refusal by a complainant to allow the prosecution to disclose medical records or material relating to the complainant's mental health may mean a case is discontinued. This is a crucial way, albeit indirect way, in which mental health issues impact attrition in rape cases. Therefore, problems of attrition and mental health span not only issues of credibility of the complainant but are also intimately woven into the very nature of other evidence that is submitted. Finally, if the material is not disclosed to the defence the prosecution would be in breach of its obligations under the CPIA 1996.

A potential remedy to this disadvantaging complainant may make a PII application in order to resist disclosure, arguing that the material is protected because it infringes her right to privacy. But if the PII application is unsuccessful, and the complainant unwilling to allow access to the material, the case is likely to be discontinued, consequently, in an indirect way mental health impacts attrition. It seems that, when deciding on PII application, courts have generally found the right to privacy to outweigh the rights of the accused where relevance is unlikely. If the complainant refuses access to her medical records then it is likely that the CPS will discontinue the case. The duty of the CPS to disclose mental health information to the defence raises concerns as to how disclosure affects a group both vulnerable to predation and less likely to report allegations of rape as they have a strong and valid fear of not being believed.

The problem of attrition is compounded by placing further procedural obstacles before an already vulnerable category of complainant. The disclosure of such material also suggests a continuing adherence to myths particularly of female

instability and mental health – and this is in an area that already suffers from a great deal of existing stigma and misunderstanding. This supports the proposition that the incidence of mental health issues can be significant among both victims of rape and those complainants whose cases are not progressed.

Admission of mental health material at trial is problematic

Chapter 6 shifted focus to the trial context and the admission of material relating to the complainant's mental health at trial, and its relevance and bearing on the outcome of the case. It examined how the material is adduced with a view to undermining credibility, and how the complainant's veracity can be undermined where her psychiatric or counselling records are disclosed in court. This draws upon misconceptions about mental health that may unfairly operate to discredit her allegation. The consequence is that the credibility of the complainant is damaged to the extent that the prosecution is unable to prove the accused's guilt beyond a reasonable doubt and he is acquitted. This illustrates how the complainant's mental health is an influential factor regarding attrition even if the case manages to progress to trial despite the earlier obstacles in the process.

It was important to consider the perceived relevance of material relating to the complainant's mental health, and the consequences of its use at trial. When considering relevance of material relating to the complainant's mental health one must consider the issue to which it is directed at trial. A common misconception is that a complainant who suffers from a mental health condition is a less reliable, i.e. less accurate, witness and the generalisation that those with mental health conditions are unable to distinguish fact from fantasy. Furthermore, such material is perceived to be relevant where it reveals that the complainant has made previous allegations,

the existence of which, the defence will then argue, suggest the complainant is lying about a current allegation.

This thesis finds that there are substantial problems created by leading evidence of this type and difficulties ensue when the evidence is used improperly or is arguably irrelevant. It relies upon misconceptions surrounding mental health and women's psychological stability. The consequences of the use of this form of evidence include juror misuse or misinterpretation of the information; it may prevent other complainant's with mental health issues from reporting allegations of rape due to the fear of humiliation at trial.

During counselling or therapy, the complainant may address topics which relate to the presence or absence of consent, or that suggest the defendant could have held a reasonable belief of consent and therefore a defence to rape. This may seem non-contentious, however the goals of therapy and the objectives of a criminal trial are very different. This thesis finds that the relevance of and the weight attributable to, counselling records is highly questionable. For these reasons the admission of information relating to the complainant's mental health can unfairly undermine perceptions of complainant credibility, thereby influencing the verdict to be one of 'not guilty' thereby affecting the attrition rate overall.

The admission at trial of material relating to the complainant's mental health in order to discredit complainants engenders a simplistic and flawed understanding of both mental illness and the relationship between mental health and complainant credibility.⁶⁷⁹ The mere fact that a complainant has received treatment for a mental illness does not, and should not, constitute sufficient evidence to support a conclusion that she is an unreliable witness. Furthermore, any mental health material

⁶⁷⁹ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) E & P 28, 36.

is unlikely to be relevant when the mental health condition precedes the events, as it has no bearing on the issue of consent or the defendant's belief in consent. The defence counsel may seek access to information about a complainant's mental health or question complainants about this evidence at trial in the hope that 'the merest hint of psychological aberration be sufficient to discredit their accounts'.⁶⁸⁰ Information derived from psychiatric or therapeutic interventions is disproportionately prejudicial to complainants because it permits general public ignorance of mental disorders to be conflated with rape myths – for example, the myth that rape complainants are fantasists and prone to fabrication.⁶⁸¹ Raitt argues that this stereotyping of mental illness reinforces gender inequalities already embedded in rape and sexual assault trials.⁶⁸² These misconceptions have serious implications for the fair administration of justice in rape cases.⁶⁸³

This chapter showed that the relevance of mental health issues and material is tenuous at best, and damaging at worst. If the value of material relating to the complainant's mental health is only to be found via negative inferences and stereotyping surrounding mental health, which defence counsel then relies upon in order to discredit the complainant before the court, then, this thesis argues, the material should not be considered relevant. A suggested policy solution would be that in the future such material should be either excluded by the judge or directions should be given to the effect that the jury is made aware of the relevance and construction of this material upon the complainant.

⁶⁸⁰ Ibid

⁶⁸¹ J Temkin, 'Digging the Dirt: Disclosure of Records in Sexual Assault Cases' (2002) 61.1 Cambridge LJ 126.

⁶⁸² F Raitt, 'Disclosure of Records and Privacy Rights in Rape Cases' (2011) 15(1) The Edinburgh Law Review 33, 48-9.

⁶⁸³ L Ellison, 'The Use and Abuse of Psychiatric Evidence in Rape Trials' (2009) 13 E & P 28, 36; J Temkin, 'Digging the Dirt: Disclosure of Records in Sexual Assault Cases' (2002) 61(1) Cambridge LJ 126.

Implications of the study

In sum, this thesis has shown that what happens at pre-trial stage is critical in shaping complainant credibility and the final evidential product. It has examined how what occurs when the original complaint is made to the police and the consequent police interview will be determinative in shaping how the complainant appears at trial. In regards to mental health evidence, it is important to ensure that correct disclosure protocols are followed and that persons involved in the criminal justice process are aware that a mental health condition is a vulnerability rather than a reason to doubt the credibility of the complainant.

This thesis has set out four key points in the investigation and prosecution of a rape allegation. It examined each stage separately to highlight the relevance and impact of mental health at each stage of the process and how the complainant's mental health was a factor influencing decisions regarding case progression.

However, if you step back and examine all stages together you can see the cross-pollination of negative effects at each stage. For example, the complainant may be fearful that her mental health will be brought up at trial and in fact, evidence is admitted in the form of counselling notes, or medical records detailing a history of depression. However, when we look back to the initial reporting stage, at this point the complainant was unsure whether to inform the police of having a mental health issue because of the stigma associated with mental health but also how this information may be used against her to discredit her account. This fear has been validated. Alternatively, a failure to identify the complainant's mental health issues could agitate symptoms because of an uncomfortable initial reporting experience at

the SARC and therefore affect the complainant's ability to give a credible and evidentially strong account during the ABE interview. This is the original contribution to the literature: this thesis devises a categorisation of how mental health affects pre-trial procedures and sets out the indirect ways in which mental health still emerges at trial. This is an additional and novel way to look at the relationship between mental health and attrition.

To summarise, there are problems within each specific stage: initial reporting, ABE interview, disclosure and trial. The complainant's mental health is influential at each of these points and each chapter addressed these concerns. However, when you consider the bigger picture the problem is even more disheartening. Although a more victim-orientated approach has been adopted following policy recommendations from the government, more needs to be done to better integrate and improve relationships between criminal justice agencies and complainants with mental health issues vis à vis early interactions with the police. For complainants with mental health issues in particular, it can be argued that the 'justice gap', i.e. the rate of attrition, will not be narrowed unless specific attention is devoted to developing investigative and prosecution strategies that provide redress for complainants with mental health issues.

This thesis has looked separately at each stage of the criminal justice process, at the problems within each stage. More concerning, is that when looking at all stages combined, there is a cumulative effect across stages. That being the case, there should be a holistic treatment of complainants with mental health issues across the stages of the criminal justice process. For example, awareness of mental health issues should be extended to both the police and the CPS, and directions should be devised to alert the jury to some common misconceptions about the value of medical

evidence at trial. The recommendation is that all participants in the criminal justice decision-making should be made aware of mental health issues and their effects, rather than just at the initial stage. It is hard enough for complainants with mental health issues to progress to trial; if they succeed in doing so, they should not be additionally victimised by the disclosure of medical records that may have no bearing on the case.

At the pre-trial stages, an awareness of the mental health condition is very relevant because the condition needs to be identified and managed accordingly to ensure the complainant manages to give the best possible account she can, but is not (or at least, should not be) nearly as relevant later. Such a holistic approach must be taken to enable the complainant that has been successful in managing to put forward her account through the initial suspicions of the police, is still succeeding through the later stages of the criminal justice process. These demands may be uneasy to achieve, yet, it is submitted that such an approach is crucial to diminishing the rate of attrition of rape cases involving a complainant with mental health issues. Future research should focus on ensuring that appropriate weight and attention is given to the existence of a mental health condition in a rape complainant at each and all stages in the process, and on the creation and implementation of appropriate policies to achieve this.

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