Service Description

This document describes a service commissioned for Avon and Somerset by B&NES CCG, Somerset CCG and BNSSG CCG. The lead commissioner for the service is BNSSG CCG and funding is provided by NHS England (Health and Justice) and the Office of the Police and Crime Commissioner for Avon and Somerset as co-commissioners.

Sexual Violence Psychological Therapies Service

Description

This is an all age service to support survivors of sexual assault and is available to all genders. The service provides therapeutic interventions and counselling to support acute victims of sexual assault and abuse (i.e. where the offence took place within the last 12 months). Interventions should comply with pre & post trial guidance (see appendix 1). The service must reflect evidence-based practice relating to sexual violence and should be trauma-informed. The service will offer 1:1 sessions alongside group work where clinically indicated.

The service will work closely with the SARC and other providers of sexual violence support services such as Independent Sexual Violence Advisor (ISVA) services across Avon and Somerset. The service will operate as part of the wider sexual assault pathway (see appendix 2) and should not be viewed in isolation. Individuals will be supported to move through the system and move onto the most appropriate step down service.

The service will work collaboratively with other agencies e.g. the SARC, ISVA provision, statutory and third sector organisations to ensure that service users receive the appropriate assessment and support. The former will ensure that transfer of care protocols take place with a clearly developed referral process which ensures that individuals have a seamless pathway. By providing the most clinically indicated intervention, the service will help reduce waiting times for therapeutic sexual violence services. The service will sign post individuals to other relevant services/organisations in Bristol, Somerset, Bath and North East Somerset, North Somerset and South Gloucestershire.

The service will work in line within NHS England's Strategy on 'Sexual Assault & Abuse' (See Appendix 3) and will take into consideration the recommendations from the 'Sexual Violence Needs Assessment' (see Appendix 4).

The service should be culturally aware and language appropriate with an understanding of the needs and wishes of diverse communities and people. The service offers a diverse workforce to represent the population being served (e.g. when requested male worker can support a male victim). The service will deliver services across the diverse geographical area of Avon and Somerset.

<table>
<tr><td colspan="2">The service is encouraged to design innovative and effective services which meet and exceed the requirements of this specification. This service will be flexible in offering support to family and carers of the survivor. The service must work where relevant in collaboration with safeguarding.</td></tr>
<tr><td>Referral route

This is an open referral route.</td><td>Referral criteria

Under this commissioning arrangement, individuals registered with a GP practice in the Avon & Somerset area can be referred to this service. The service will operate within the Avon & Somerset Constabulary boundary for people who reside in it, i.e. B&NES, BNSSG & Somerset.

Individuals eligible for the service will meet the following criteria:

- Sexual assault within the last 12 months

The service is expected to make reasonable adjustments for meeting the needs of service users with Protected Characteristics.[1]</td></tr>
<tr><td>Indicative staffing

The provider is responsible for ensuring sufficient staffing is in place to meet the quality and performance indicators specified in the contract. Appropriate skill mix will be provided to ensure sufficient clinical expertise for this client group.</td><td>Operating hours

To be decided by the provider based on need of the individuals (eg. consideration for delivering sessions in the evenings and weekends).

It is anticipated this service will be operated on a sessional basis.</td></tr>
<tr><td colspan="2">Whole System Approach
This service should be considered one component of whole health and social care system and forms part of the wider SARC model of care, aimed to prevent, treat and manage people’s needs post sexual assault.</td></tr>
<tr><td colspan="2">Reporting requirements
In order to provide assurance that the services are delivering safe, high quality services in line activity levels commissioned, the providers are</td></tr>
</table>

[1] Protected characteristics include but are not limited to: disability, gender reassignment, sex, homelessness, substance misuse, religion or beliefs, race

expected to report the data on a service level. Reporting requirements are detailed in the service outcome document (see Appendix 5).

Appendix 1

- https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-vulnerable-or-intimidated-adult-witnesses
- https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-child-witnesses-prior-criminal-trial

Appendix 2

30_sexual_assault_services.pdf

Appendix 3

strategic-direction-sexual-assault-and-abu

Appendix 4

Draft Sexual Violence Needs Assessment fo

Appendix 5

Sexual Violence Psychological Therapi

Department of Health

NHS England

Public health functions to be exercised by NHS England

Service specification No.30

Sexual assault services

November 2013

Published to gov.uk, in PDF format only.

www.gov.uk/dh

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations**	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference:	**00736**
Document Purpose	Resources
Document Name	Public health functions to be exercised by NHS England service specification no 30: Sexual assault services
Author	NHS England
Publication Date	11 November 2013
Target Audience	NHS England Regional Directors, NHS England Area Directors
Additional Circulation List	CCG Clinical Leaders, Directors of PH
Description	This specification is part of an agreement made under the section 7A of the National Health Service Act 2006. It sets out requirements for an evidence underpinning a service to be commissioned by NHS England for 2014-15. It may be updated in accordance with this agreement
Cross Reference	
Superseded Docs (if applicable)	18368
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Direct Commissioning NHS England 4-8 Maple Street London W1T5HD 0113 8250550

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Public health functions to be exercised by NHS England

Service specification No.30

Sexual assault services

Prepared by –

Violence and Social Exclusion Team, Department of Health

Contents

Service specification No.30

This is a service specification within Part C of the agreement ‘Public health functions to be exercised by NHS England’ dated November 2013 (the ‘2014-15 agreement’).

The 2014-15 agreement is made between the Secretary of State for Health and NHS England under section 7A of the National Health Service Act 2006 (‘the 2006 Act’) as amended by the Health and Social Care Act 2012.

This service specification is to be applied by NHS England in accordance with the 2014-15 agreement. An update to this service specification may take effect as a variation made under section 7A of the 2006 Act. Guidance agreed under paragraph A38 of the 2014-15 agreement may inform the application of the provisions of this service specification.

This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

The 2014-15 agreement including all service specifications within Part C is available at www.gov.uk (search for ‘commissioning public health’).

1. Purpose of service

National/local context and evidence base

1.1. Acts of sexual assault are crimes that are governed by the Sexual Offences Act 2003 (England and Wales). A distinction is made between sexual assault and serious sexual assault. A "rape" or serious sexual assault occurs when someone 'intentionally penetrates the vagina, anus or mouth of another person with his penis',[1] that the other person does not consent to the penetration, and the perpetrator 'does not reasonably believe that the other person consents'. There is also a separate offence of assault by penetration when someone 'intentionally penetrates the vagina or anus of another person with a part of his body or anything else'. Sexual assault is non-consensual sexual touching where the perpetrator has no reasonable belief that the victim is consenting. Sexual activity with a child under 16 is an offence, including non-contact activities such as involving children in watching sexual activities or in looking at sexual online images or taking part in their production, or encouraging children to behave in sexually inappropriate ways.

1.2. Sexual violence is predominantly a crime against women, children and vulnerable adults which may be contextualized in gender, equality and inequalities policies. The obligation to provide accessible and integrated services to victims of sexual violence is affirmed in Articles 24 and 25 of the Council of Europe Convention on Prevention and Combating Violence against Women and Domestic Violence (CAHVIO). The UK Government became a signatory of the Convention in June 2012[2] and is already obliged to observe other international obligations to take actions to mitigate violence against women and children, including the United Nations Conventions on the Rights of the Child (UNCRC)[3] and on the Elimination of all Forms of Discrimination against Women (CEDAW).[4] These are also reflected in the Government's strategy, Call to end Violence against Women and Girls.[5]

1.3. In this service specification, sexual assault, sexual offence, sexual violence and sexual abuse are used interchangeably and not necessarily in their technical or legal definitions. Sexual assault referral centres (SARCs), many still based on police referrals, describe the current service model in England and actual local facilities; but the term sexual assault services is used to describe existing services generically and in reflection of the direction of travel towards more open access, self-referral services (see paragraphs 1.10 and 6.7).

1.4. The annual incidence of sexual violence reported to the Police at just under 55,000 lies between that for strokes (60,000) and coronary heart disease (46,000) in women in the UK.[6] However, sexual violence is under-reported as a crime. Only 11% of victims of serious sexual assault told police about the incident[7] and few reveal the experience of prior sexual assault when using healthcare facilities. In 22.9% of cases where a young

person aged 11-17 was physically hurt by a parent or guardian, nobody else knew about it. The same applied in 34% of cases of sexual assault by an adult and 82.7% of cases of sexual assault by a peer. [8] The same research report by the National Society for the Prevention of Cruelty to Children in 2011 found declining rates of sexual abuse in children under 16 years old (5% in 2009). However, the health consequences for sexually abused children and young people can be quite devastating:[9]

- Abused children are more prone to sexually transmitted infections.
- Abused young people are at increased risk of homelessness, which may result in risk-taking behaviours and increased vulnerability.
- The risk of suicide doubles for abused young people when they reach their late twenties.
- Sexually abused adolescents are at risk of ongoing health problems such as chronic pelvic pain and gynaecological problems.
- Sexual abuse in children and young people is associated with mental ill health including self-harm and depression, which may continue into adulthood.

1.5. The relatively high prevalence of sexual violence in young women is worse for those with pre-existing vulnerabilities and for some, may be associated with several other life risks. Emerging and unpublished analysis from the Youth Justice Liaison and Diversion pathfinder scheme data set suggests that young women in gangs have some of the highest health and social vulnerabilities including sexual assault (x11) compared to the broader group (x2). The analysis is currently being tested for statistical significance but at the moment, 18.9% of girls in gangs experienced sexual assault compared to 6.1% reported by their non-gang counterparts. 24% of girls in gangs were taking part in sexually harmful and exploitative activity compared to 5% of their peers who were not in gangs. Although not correlated with sexual violence, 21% of the cohort were currently looked after children, a quarter had been looked after and a quarter were on current child protection plans.

1.6. Thus, sexual violence may have life-long psychosocial consequences, which may affect personal economic ability. More broadly, sexual violence can worsen the impact of inequalities in women, the vulnerable and the disadvantaged, and is often linked to domestic violence. The long-term effects of sexual violence are associated with depression, anxiety, post-traumatic stress disorder, psychosis, drug and substance misuse, self-harm and suicide and have a higher prevalence reported amongst young people. Research increasingly links the post-traumatic stress following sexual violence with mental illness and there is an association between child sexual abuse that is validated at the time, and a subsequent increase in rates of childhood and adult mental ill health.[10] There is also evidence suggesting that 40-60% of people receiving mental health services self-report a prior history of childhood sexual or physical abuse or both.[9] Mental health assessment is key to discovery of previous sexual assault and along with

the response, is therefore critical in aiding the pathway to recovery. A recent analysis of the Adult Psychiatric Morbidity Service reported as follows:[11]

"*One of the groups, representing 1 in 25 of the population (around 1.5 million adults) had experienced extensive forms of both physical and sexual violence, with an abuse history extending back to childhood. Nearly everyone in this group had, at some point in their life, been pinned down, kicked or hit by a partner. Half had been threatened with death. Most had been sexually abused as a child and some severely beaten by a parent or carer. Many had also been raped as an adult. Over half the members of this group had a common mental disorder such as clinical depression or anxiety. However, only 10% were in receipt of counselling or a talking therapy."*

1.7. Over the past few years, the Association of Chief Police Officers and HM Inspectorate of Constabulary have promoted services to victims and better recording of police-recorded crime and there are improvements in the latter though variable. Although it is not possible to provide separate figures for England and Wales, latest figures from the 2010-11 British Crime Survey(BCS) and Police Recorded Crime statistics show for England and Wales show:[7]:

- *A 1% increase in the number of Police-recorded sexual offences to 54,982 recorded by the Police; a smaller rise than the previous year but following a longer-term decline in sexual offences recorded since 2005-06.*
- *Police figures show a 4% increase to 45,326 in serious sexual "offences" (rape, sexual assault and child sexual abuse) and a 12% decrease in other sexual offences (such as unlawful sexual activity and exploitation of prostitution and soliciting). This latter figure is particularly sensitive to changes in local police activity rather than changes in reporting by victims.* However, BCS estimate no change in the overall prevalence of sexual assault between 2009-10 and 2010-11.
- *Most reported rapes (serious sexual assault and child sexual abuse) are in women and children. Female reported rapes increased by 5% to 14,624 (of which 76% were in young people under 16 years old).*
- *Male rapes increased by 12% to 1,310 (35% in young people under 16 years old) and sexual assaults on a male increased by 7% to 2,412.*
- 1 in 40 (2.5%) women aged 16-59 and 1 in 200 (0.5%) men had experienced a sexual assault (including attempts) in the last year.
- The 2008/9 British Crime Survey self-completed questionnaire indicates that around 10,000 women are sexually assaulted and 2,000 women are raped each week.
- It is estimated that about half of women (40% - 50%) who have experienced domestic violence are raped within their physically abusive relationship.[12]

NB: For the figures above BCS survey analysis is in straight font and police recorded analysis is in italics

- Unpublished data from Her Majesty's Inspectorate of the Constabulary in June 2012, documents declining rates in the detection of all male and female rapes from 29% in 2008/9, to 24% in 2010/11. There are multiple factors that contribute to this in the criminal justice pathway, including but not exclusively, the quality of forensic medical examination.

See section 2.2 for data on the use of services

The Need for Specialist Sexual Assault Services

1.8. The dual benefits of dedicated services for the health and well-being of victims of sexual violence and delivery of justice are considerable. Such a service will provide clients with the opportunity for high quality health care, independent sexual violence advice and the opportunity for forensic medical examination and sampling. This, where the clients consent, provides both the Police and the client with the best possible opportunity to recover evidence for use within an investigation. Without such an approach, support to clients, including consideration of initiating criminal proceedings would be relatively reduced and disjointed.

1.9. There are also significant knock-on benefits to the NHS for an integrated early response to sexual assault across the comprehensive health system, including the voluntary and community sector and criminal justice system. In 2003-4, each adult rape was estimated to cost over £76,000 in its initial emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health services and costs incurred in the criminal justice system.[13] The overall cost to society of sexual offences in 2003-04 was estimated at £8.5billion but this did not include long-term health impacts such as post-traumatic stress disorder or mental health costs.

Service Models

1.10. At present, sexual assault referral centres (SARCs) are the typical model of service provision for victims of sexual violence in England and expectations of the "minimum elements" for a SARC service were set out in a document published jointly by the Department of Health, Home Office and Association of Chief Police Officers.[14] This guide, still extant for commissioners of sexual assault services, is being updated to reflect the revisions recommended in the University of Birmingham feasibility study on transferring SARC commissioning from police forces to the health services.[15] The SARC takes an integrative approach but other models of sexual assault services in other countries have been documented which show a wider scope for self-referrals and/or integration with the wider health system, the voluntary and community sector and criminal justice.[16] Only 11%

of adults who experience rape report to the police. Thus, many more use counselling and support services in the voluntary sector than SARCs. About 84% of referrals to SARCs in England are through local police, which may be a hindrance for victims who do not wish to follow a criminal justice pathway, even though on access, SARCs give choice to victims to receive healthcare only or involve the police.[15] SARCs also provide an onward referral to the voluntary and community sector specialist sexual violence services as well as take clients referred from there. Integrated working with the sector, in a way that is underpinned by collaboration between the various commissioners is vital for appropriate funding flows to the voluntary and community sector for choice of complementary services. [17]

Service Data

1.11. There is no minimum data set for services but many providers collect their own data, some of which are shared regionally for benchmarking. However, the picture is variable on returning routinely collected data to commissioners for performance management. A central data set that used to be returned to the Home Office on an informal basis by every service provider ceased to be returned in 2009. Sexual assault indicators relating to the Public Health Outcomes Framework are due to be issued shortly. The data collection and definitional problems in SARC services have limited it to levels of sexual violence and rape as currently reported to the Police. This would enable commissioning partners to engage in local conversations about what is happening locally nonetheless, commissioners would want to develop and agree common data definitions for both performance and outcomes management.

2. Scope of service

Aims and objectives of service

2.1. NHS England is expected to commission jointly with police forces and local authorities in England (see paragraphs 6.1 to 6.3 for commissioning and funding responsibilities) a cost-effective, integrated public health service response to sexual violence and rape that will meet needs identified through joint strategic needs assessment expressed through health and well-being board strategies, taking into account users' views and the national standards set out at section 3. In so doing, the Board will take all reasonable steps to assure improvement in:

- the quality of services to victims whilst ensuring integrated care pathways to other health and healthcare services, safeguarding, social care and criminal justice services;
- access to long-term support from third sector specialist sexual assault services (provide advocacy, counselling and support), NHS psychological therapies and appropriate mental health services;
- victim's experience and satisfaction with access, healthcare, ancillary forensic medical examination and follow-up after-care;
- the supply of competent forensic examiners in sexual assault services, including paediatric forensic medical examiners;
- clinical governance and peer review in sexual assault services;
- safeguarding sexually-assaulted children, young people and vulnerable adults;[18, 19, 20, 21]
- facilitating decisions to prosecute in cases of rape and sexual assault through improved forensic medical provision for both children and adults;
- equity of access in sexual assault services across England and in keeping with the requirements of the Public Sector Equality Duty of the Equality Act (2010). This includes the majority of victims who are women and girls, as well as for people across all the protected characteristics of the Duty.[2, 3, 4, 22,]

2.2. Violent crime, including sexual violence is included in the indicators on improving the wider determinant of health, in the Public Health Outcomes Framework.[23] However, due to data quality issues for police-recorded crime, and the British Crime Survey data not being aggregatable in sufficient numbers to every local authority area, options for a

sexual violence indicator have been developed by Department of Health and Home Office and are expected to be published soon.

Service description and use

2.3. Sexual assault referral centres (SARCs) are an open access one-stop service to help victims of rape or sexual assault, irrespective of age, on the journey to recovery by providing an immediate health and care response with access to criminal justice services, safeguarding services and integrated follow-up.[14] For children and young people, it is critical that the sexual abuse is managed as part of their total health and developmental needs and is integrated with local healthcare, children services and safeguarding arrangements. Many local areas have developed their own care pathways. The examples at Appendices 1 and 2 for adults and children are one of many existing approaches. [24, 25] This example focuses on the journey in and out of SARCs and shows how clients access the service and the various agencies engaged in delivering it. SARCs should provide:

- 24/7 or out of hours provision;
- timely acute healthcare assessment, including paediatric assessment, mental health risk assessment, treatment (public health services including emergency contraception, pregnancy and STI testing and post exposure prophylaxis) and crisis support;
- choice of gender of forensic examiner – most victims prefer to be seen by a female examiner;[26]
- timely and comprehensive forensic recovery, if the client chooses and for young people under 16 years old, timely paediatric forensic recovery;
- follow-up services which address the client's medical, safeguarding, psychosocial and on-going needs, including onward referral to other health and mental health services, NHS psychological therapy services[27] and specialist sexual violence psycho-social counselling and support (often undertaken by voluntary and community service providers);
- direct access or referral to an independent sexual assault advisor (ISVA). An ISVA is a trained support worker who provides advice and support to enable clients to access the services that they need. A report funded by the Home Office shows that clients supported by ISVAs are more likely to go through the full course of criminal justice proceedings;[28]
- access to the criminal justice system if the client chooses.

2.4. There are now 37 SARCs (see section 5) but the services they provide in relation to the above criteria are variable as set out in the *Revised National Service Guide* as the minimum elements[14]. Findings from the University of Birmingham Feasibility Report commissioned by the Department of Health and Home Office, and which are generalizable, are being used to update the Revised Guide. In summary, the Study shows that in 2009/10: [15]

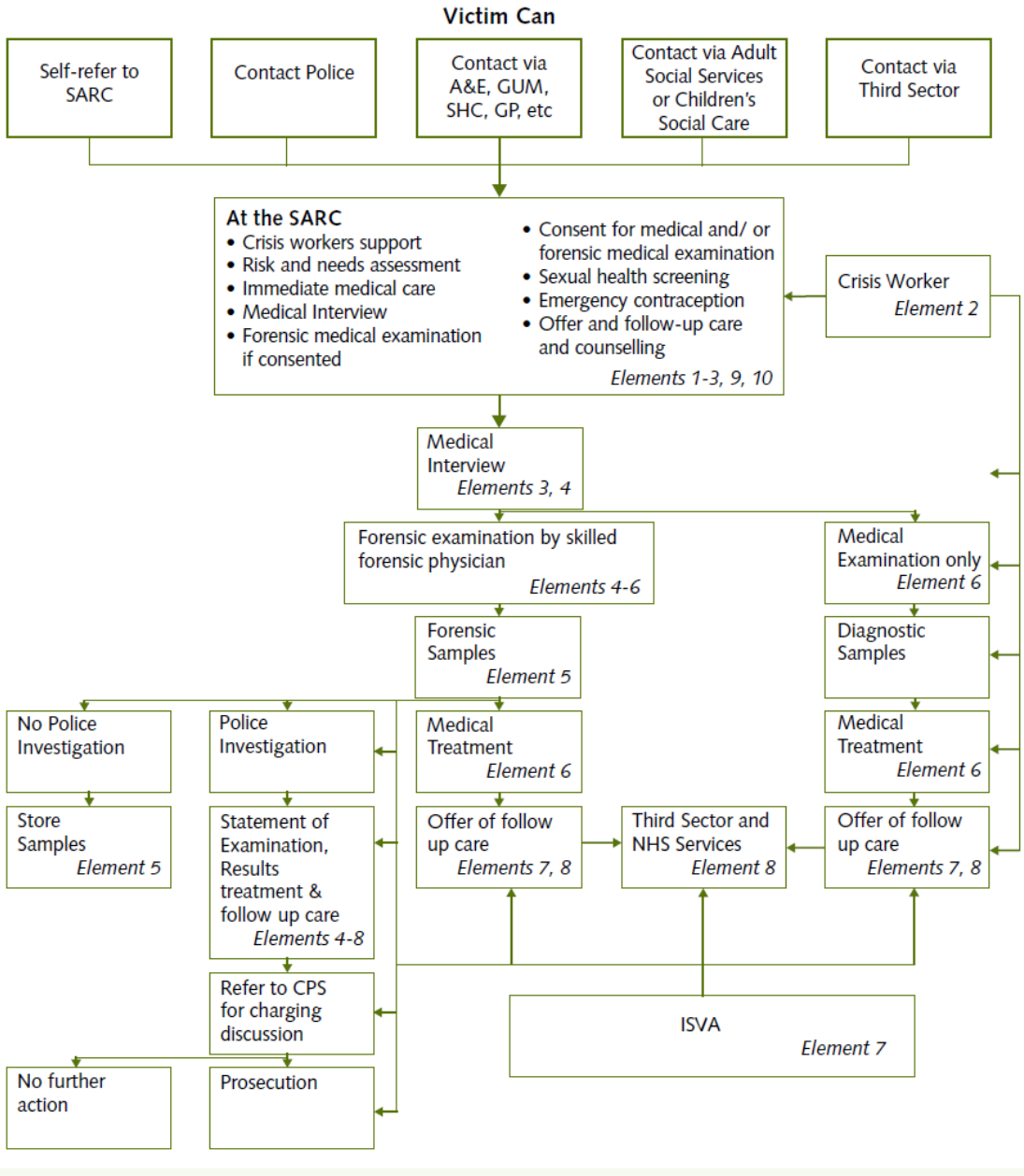
- The 28 SARCs across the country covered 68% of population and 56% of the geographical area;
- sympathy suites located in police custody facilities covered the remaining 32% of the population and 44% of the area, suggesting that care would be disjointed and focused largely on the forensic medical examination, with multiple referrals to services such as independent sexual violence advice, contraception, screening for sexually transmitted diseases and HIV prophylaxis, and safeguarding. The Government's policy intention is to move away from this model of provision. Sympathy suites are not adequate for the holistic care that sexually assaulted people need.[5,15,29, 30] However, the numbers of these facilities are diminishing as more SARCs open;
- population density per sq mile for SARCs was 1253 compared to 735 for sympathy suites, which covered areas that are more rural. This may indicate the need for different service models to concentrate the specialist skills needed for forensic and paediatric care;[31, 32, 33]
- on average, there were 27 referrals to SARCs and sympathy suites/100,000 population (min at 1.5, max at 66.3). The interquartile range yields a more accurate indicator between the Lower Quartile of 18.9 referrals per 100,000 population and the Upper Quartile of 36);[15]
- on average 33% of referrals were in young people below 18 years (this age group account for 21% of the country's population). In different areas, this proportion ranged between 17% and 50% with many being historic cases (outside the forensic examination window i.e. over 7 days since the assault):

Care Pathway

2.5. A high-level sexual assault care pathway diagram is set out below. The elements therein refer to the expectations for delivery of a SARC service as set out in the joint Department of Health, Home Office and Association of Chief Police Officers guide.[14] Adult victims of sexual violence, but also children in particular, can access services through SARCs or through more routine health care, social care, the specialist third sector or police referral. Many local areas have developed care pathways in and out of SARCs in relation to these

multiple points of access. Examples of these more detailed care pathways are at Appendices 1 and 2. Some of these include timelines for services as a guide for local determination. References to “pre-trial” therapy in these diagrams, means therapy received by victims before their court cases are held, to help prepare them for what might be a very difficult ordeal.

Figure 1: Sexual Assault Referral Centres – Pathways and Minimum Elements



Population covered

2.6. Any one in England, who has been a victim of sexual assault (recent or historic), irrespective of age, gender, sexual orientation, disability or any other protected characteristics.

Any acceptance and exclusion criteria

2.7. None at present.

Interdependencies with other services

2.8. In April 2013, custody healthcare services came within the scope of the direct commissioning by NHS England and this includes health services commissioned for SARCs, which are a public health service. Responsibility for forensic medical examination in both custody healthcare and sexual assault remain with individual police forces but work continues to transfer the commissioning of both custody healthcare and SARCs to NHS England.

2.9. In terms of resource use in the immediate response to sexual violence, there are other interdependencies, chiefly with sexual health, HIV, genito-urinary (GUM) services, which are being commissioned by local authorities as well as abortion services. GUM and Sexual health professionals believe that they see many victims of sexual assault in their services, especially in relation to very vulnerable groups such as looked after young people, sexually-exploited young people and asylum seekers. There are also wider interdependencies with the criminal justice system, the comprehensive health care system and in particular with NHS mental health and improving access to psychological therapy[27] commissioned by clinical commissioning groups as well as wider police healthcare in relation to vulnerable people. The specialist sexual violence voluntary sector, has also articulated a clear case for choice of provision in support and counselling following sexual assault and the need for funded care pathways.[17] Partnerships are therefore essential, both for strategic commissioning by the NHS CB and others, and in the development of contract service specifications and delivery models in these interdependent areas.

Public health functions to be exercised by NHS England

3. Applicable service standards

Applicable national standards e.g. NICE, Royal College

3.1. A range of national service standards, professional standards and legislative requirements as follows:

- British Association for Sexual Health and HIV – Guidelines.

- Department of Health, Home Office, Association of Chief Police Constables. Revised National Service Guide- A Resource for Developing Sexual Assault Referral Centres 2012 (updated version being published in 2012).

- Department of Health, Home Office**.** No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.
- Equality Act, 2010.
- Faculty of Forensic and Legal Medicine. Recommendations for the Collection of Forensic Specimens from Complainants and Suspects.
- Faculty of Forensic and Legal Medicine. Operational procedures and equipment for medical rooms in police stations and victim examination suites.2007.
- Faculty of Forensic and Legal Medicine, Royal College of Paediatrics and Child Health, Association of Chief Police Officers. Guidance for best practice for the management of intimate images that may become evidence in court. 2010.
- Feasibility of Transferring Budget and Commissioning Responsibility for Forensic Sexual Offences Examination Work from the Police to the NHS. 2011.
- Faculty of Sexual and Reproductive Healthcare – Clinical Guidance.
- HM Government. Working Together to Safeguard Children 2013: A Guide to Interagency-Working to Safeguard and Promote the Welfare of Children.
- Intercollegiate Safeguarding Children and Young People: Roles and competences for health care staff. 2010.
- Guidelines by the National Institute for Health and Clinical Excellence:
  - Post-traumatic stress disorder
  - The treatment and management of depression in adults
  - Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults: Management in primary, secondary and community care
  - Pregnancy and complex social factors

  - Postnatal care
  - Drug Misuse: Psychosocial interventions
  - When to suspect child maltreatment
  - Depression in children and young people
- Royal College of Paediatrics and Child Health, Faculty of Forensic and Legal Medicine. Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse. 2007
- Royal College of Paediatrics and Child Health, Royal College of Physicians, Faculty of Forensic and Legal Medicine. The Physical Signs of Child Sexual Abuse, An Evidence-based Review and Guidance for Best Practice. 2008

Applicable local standards

3.2. Variations to local standards are permissible where these are above national or international standards.

Applicable international standards

3.3. International requirements to which the UK government is a signatory include the following:

- Council of Europe Convention on Preventing and Combatting Violence against Women and Domestic:
  - Articles 23, 24.
- United Nations Convention on the Elimination of all Forms of Discrimination against Women:
  - The Convention;
  - Option Protocol to the United Nations Convention on the Elimination of all Forms of Discrimination Against Women;
  - General Recommendations of the Committee on the Elimination of Discrimination against Women.
- United Nations Convention on the Rights of the Child:
  - Articles 19 – protection from being hurt, violence, abuse and neglect;
  - Articles 34 – protection from sexual abuse;
  - Article 39 – help for hurt, neglect, abuse, exploitation, torture, Inhuman or degrading treatment or punishment.

4. Key service outcomes

- Cost-effective and innovative services that are accessible and client-centred in meeting victims' needs for a health response and onward referral in the immediate aftermath of sexual assault or historic cases (outside the forensic window of 7 days from the assault).

- Consent-based, fit for purpose forensic recovery, preservation, reporting of evidence and feedback to victims.

- Increased client satisfaction with sexual assault services.

- Improved and equitable distribution of integrated, high quality and readily accessible, 24/7, one-stop open access sexual assault services to victims of rape, sexual violence and sexual abuse across England regardless of age, gender or sexual orientation.

- Sexual assault services commissioned jointly (see paragraph 6.3), well promoted locally and delivered through partnerships.

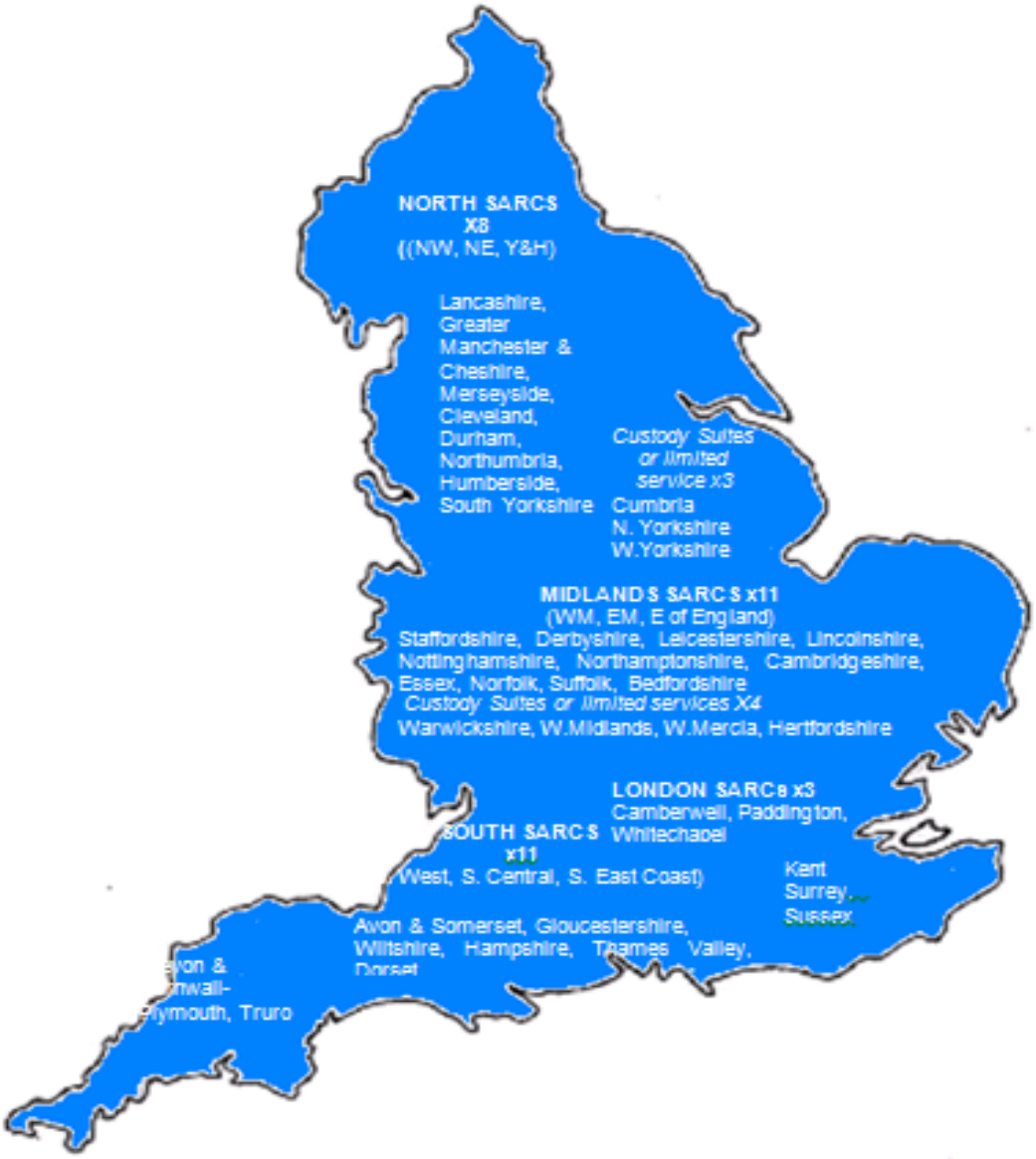
- Use of indicators for sexual violence, developed as part of the violence indicator set (1.12) in the Public Health Outcomes Framework.[34]

- Key deliverables for NHS England for the commissioning of SARCs for 2014-15 can be found in Table 3 of the NHS public health functions agreement 2014-15.

- This sets out the deliverable that the core offer should include roll-out of the provision of HIV starter prophylaxis in all SARCs in 2014-15.
- Improved commissioning of the paediatric aspects of sexual assault services provision jointly with police partners

5. Location of provider premises

Locations of the 33 SARCs in England during 2012 are shown on the map below. An additional 4 SARCs have since opened. Forensic sexual assault provision in police custody examination suites (sympathy suites) are also indicated by Force.



6. Commissioning

Commissioning Models

6.1. The 39 police forces in England are currently the commissioners for forensic services including forensic medical examination and independent sexual violence counsellers, in SARCs and police custody suites. The NHS has a responsibility for commissioning the public health and care aspects of services to victims and has focused this through SARCs only. Local authorities contribute, though not uniformly or consistently, to crisis workers in SARCs and to specialist sexual violence after care support such as is available in the third sector, for both users and non-users of SARCs. In the past, some of the previous PCTs also contributed to these.

6.2. Funding streams for commissioning SARCs are multiple and are typically brought together through collaborative commissioning with the police forces, NHS England's Public Health ring-fenced budget and local authorities, but historically, levels of full collaboration have been variable and also impact on commissioning models. NHS England published 'Securing excellence for the commissioning of sexual assault services' its operating model for how it would secure the best possible outcomes for victims of sexual violence. Working with partnerships is central to the model.[35]

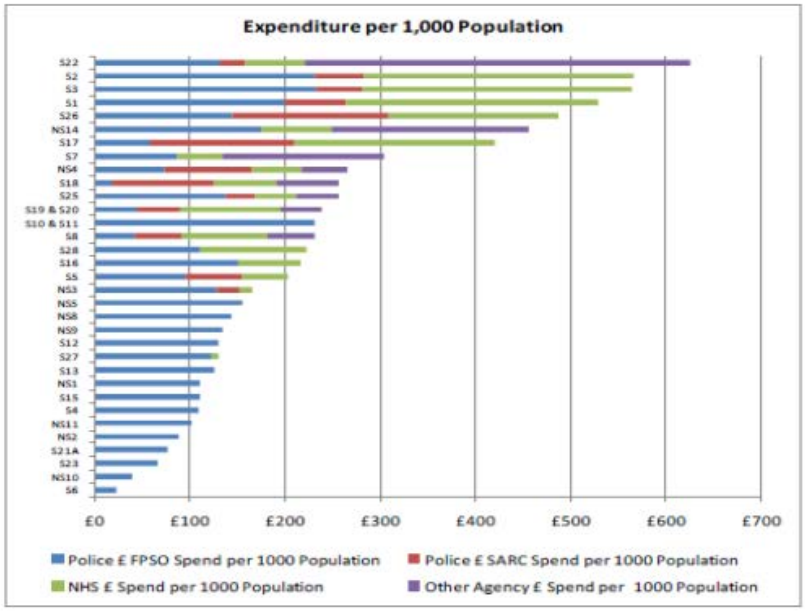
6.3. The population-standardised figures further below for agency spend on SARCs are a proxy for funding streams. However, where costs were not separated out for SARCs in joint forensic medical contracts with custody healthcare (in 17 cases), an apportionment of 10% was used to determine the costs of forensic physicians for sexual offences (FPSO) examination, which maybe an underestimate. Nonetheless, taken along with the findings on existing poor commissioning of SARCs, it shows a wide inequity of resource provision across the country, and understates the NHS contribution (as some NHS Trusts provide support in kind such as premises and running costs).[15] NHS England has now reviewed the spending for 2014-15 with the aim to ensure a more equitable distribution of spend.

6.4. Public health services for people who experience sexual violence remain a responsibility of the Secretary of State, whilst currently custody healthcare and the forensic medical aspects of both services are a police responsibility. In the last six months of the financial year 2012/13, 34 of the 39 police force areas in England were participating in the voluntary Police Transfer Programme (PTP) for collaboratively commissioning custody healthcare and SARCs with their multi-agency partners. Notwithstanding these technical differences, the policy on the PTP continues to provide a voluntary and structured partnership approach to collaboration between the responsible commissioners for both

custody healthcare and sexual assault services across criminal justice, health and care locally. The experience should also help to facilitate the potential national transfer of commissioning responsibility for custody healthcare and police-commissioned forensic medical provision for sexual assault in the longer term.

6.5. Commissioning of custody healthcare services as part of justice health services by NHS England is therefore providing an invaluable opportunity to align economies of scale and quality in the operating model for sexual assault services within which SARCs play a key part.[35] SARCs are low volume and relatively low cost services. It is therefore possible to achieve scale economies in NHS England's commissioning model based on national standards, national specifications that enable local variation worked through the ten Area Teams of NHS England with dedicated Justice Health commissioners, in contrast to having 39 individual police force commissioners. Nonetheless, a more regional or sub regional approach to commissioning SARCs is not uncommon and is the model adopted in some high population density areas such as London and Greater Manchester (now also in collaboration with Cheshire). It is also documented as offering the best prospects for child sexual assault paediatric forensic services.[16,31]

Per Capita Spend by Agencies (£ per 1000 population)



Issues for Commissioners

6.6. Because custody healthcare and SARCs involve forensic medical recovery, albeit from very different clinical expert bases, there is nonetheless, an advantage in bringing together their commissioning capacities. This is already happening in the PTP. However,

there are also distinct differences as follows, which the NHS England would need to address in their partnerships in taking forward their preferred operating model.[35] The first two points of differences below, also directly affect the quality of forensic recovery offered in SARCs:

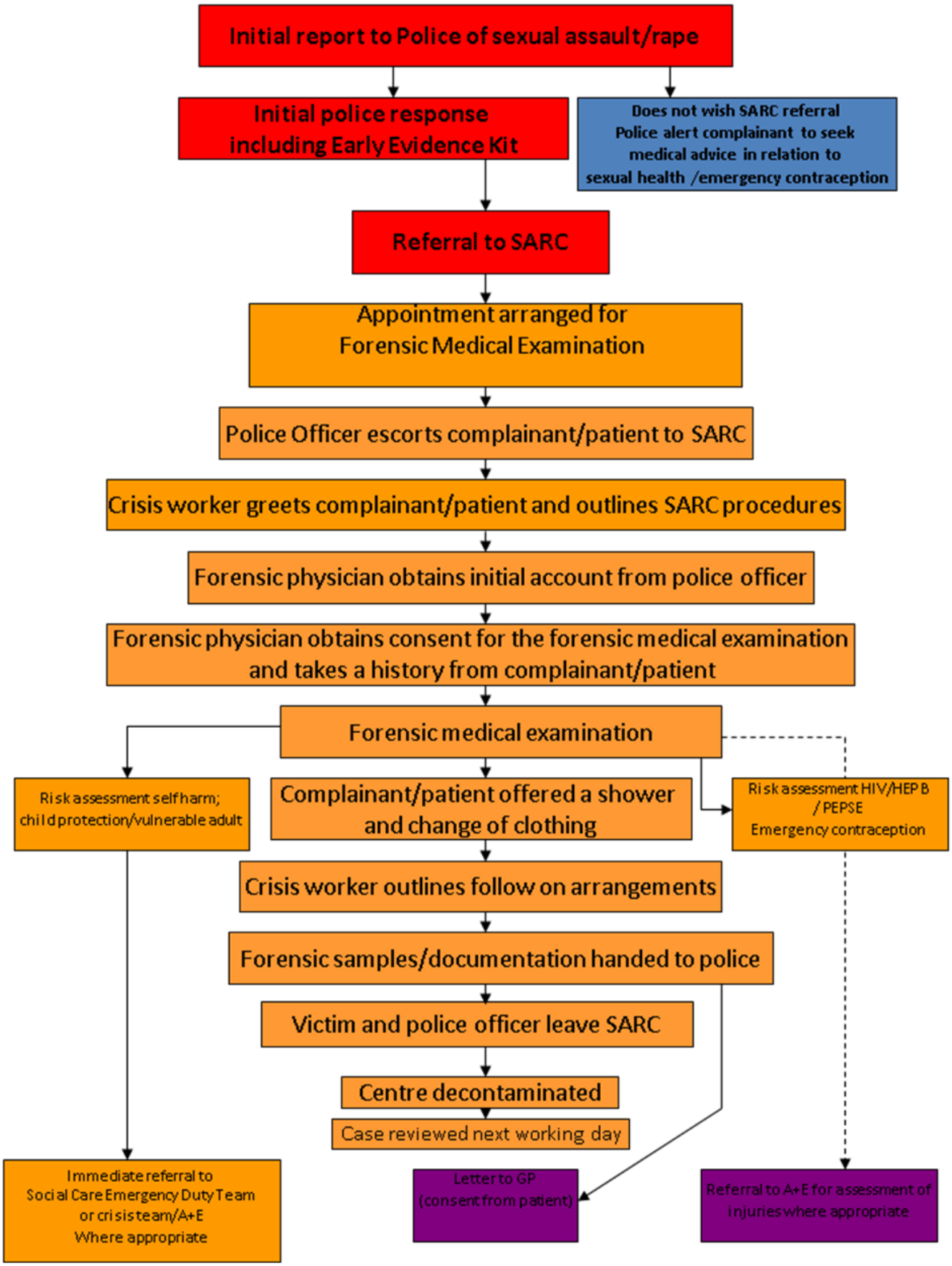
- The need for continuing expert capability in commissioning sexual assault referral services as part of healthcare and criminal justice services;
- victims, including male victims, prefer to be seen by female doctors (see paragraph 2.3 above);
- stakeholders, sensitive about subsuming sexual assault services under a commissioning system named “offender health” which is also securing services for sexually assaulted people as who are victims of crime, have welcomed NHS England’s badging of both under “justice health.”

Commissioning Specifications for Contracting

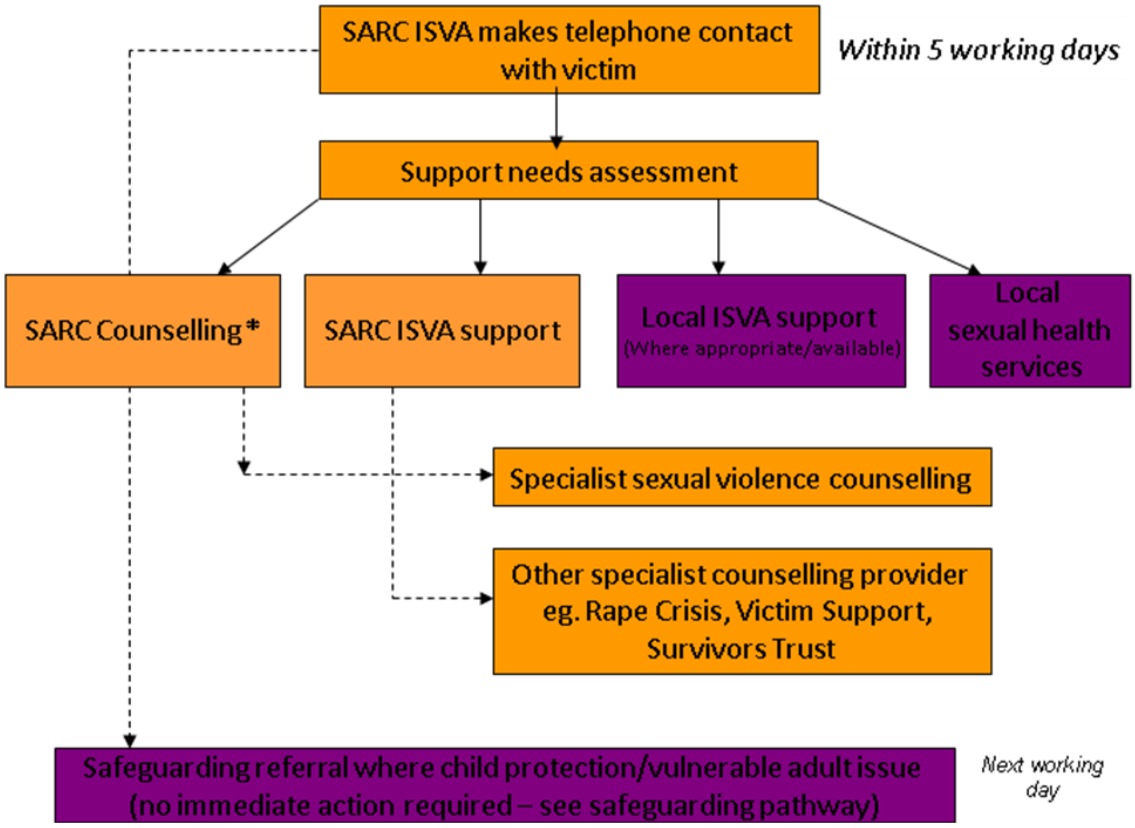
6.7. The SARC commissioning service specification developed by NHS London and modelled on the NHS contract, has been available as a model in NHS England for customised use by partnerships in its Area Teams.

Appendix 1: Example Adult Pathways

SARC Adult Care Pathway (police case): Initial attendance at SARC

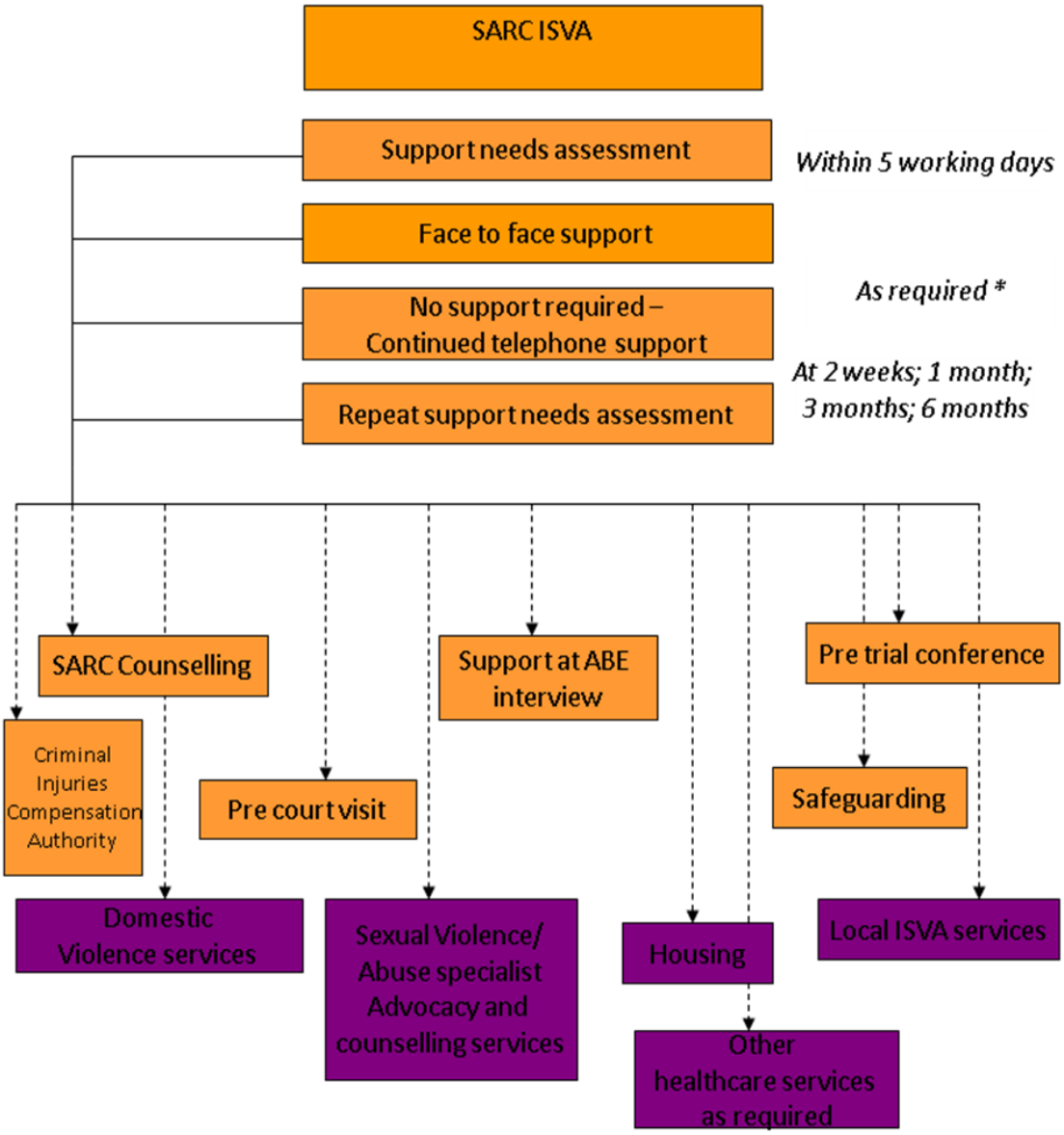


SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate)

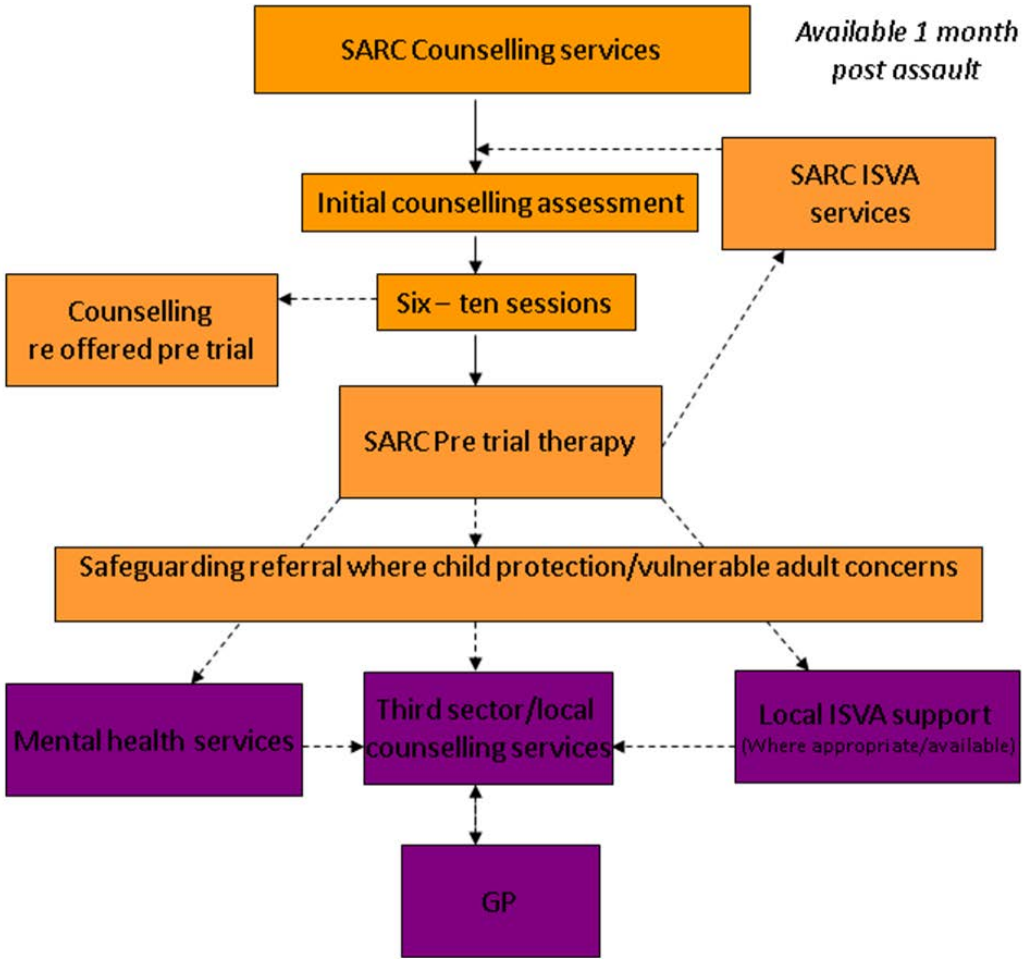


*** SARC Counselling also refers to specialist sexual violence counselling in the community e.g. Rape Crisis**

SARC Follow-up Adult Care Pathway (police case): SARC ISVA or SARC (as appropriate) - range of support services

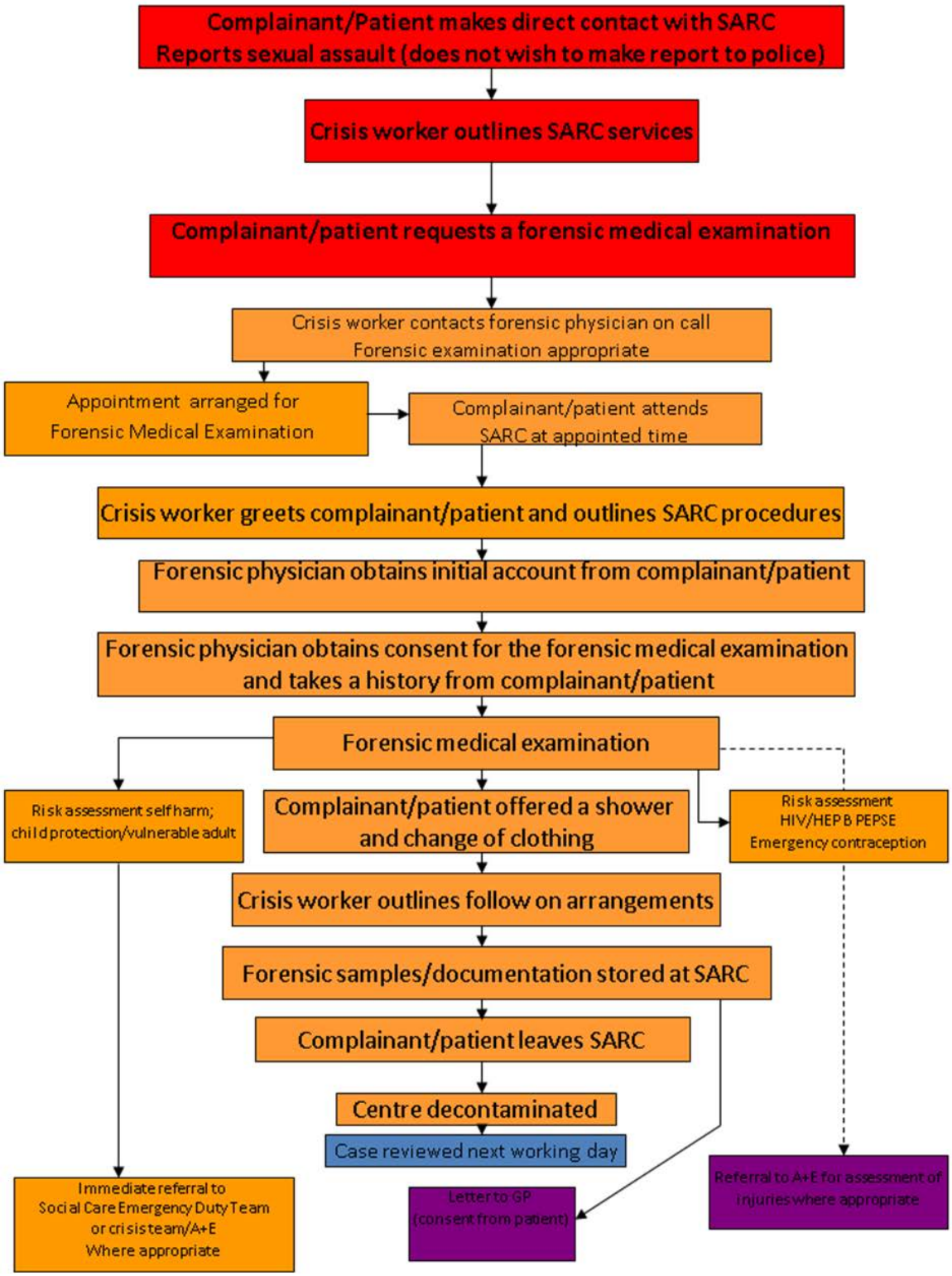


SARC Follow-up Adult Care Pathway (police case): Counselling services

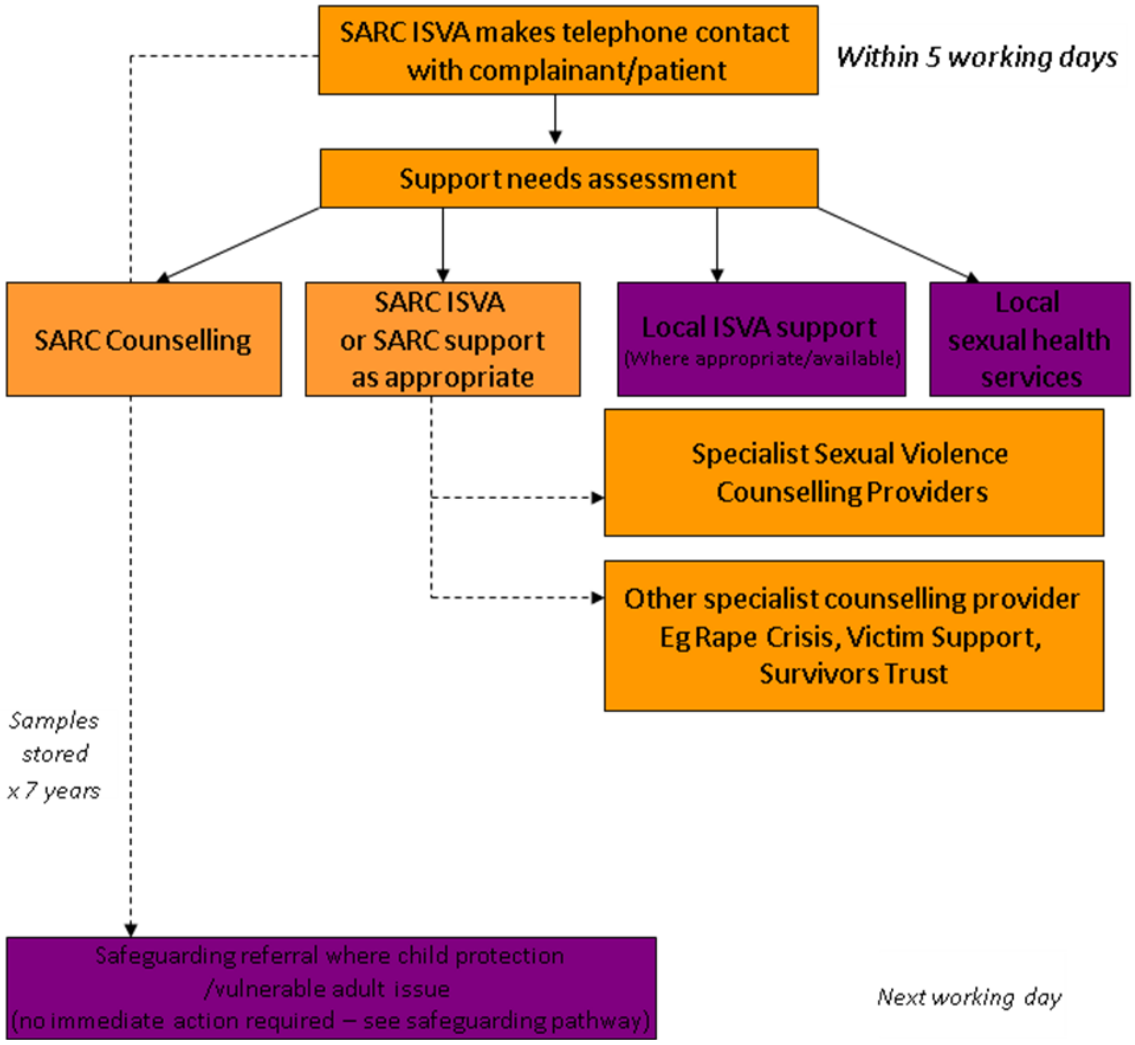


(*note:Third sector = Third sector specialist sexual violence services)

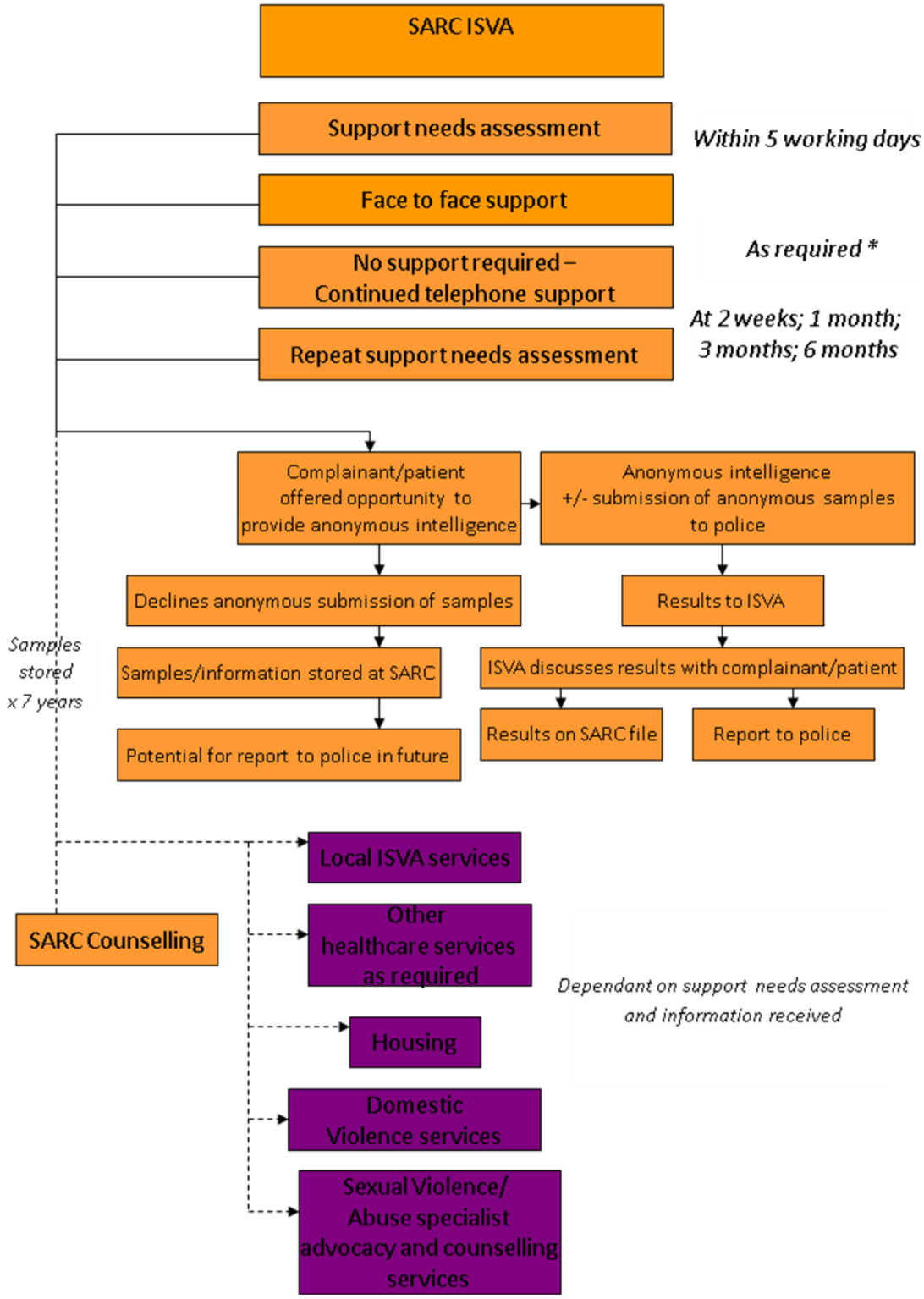
SARC Adult Care Pathway (self-referral): Initial attendance at SARC



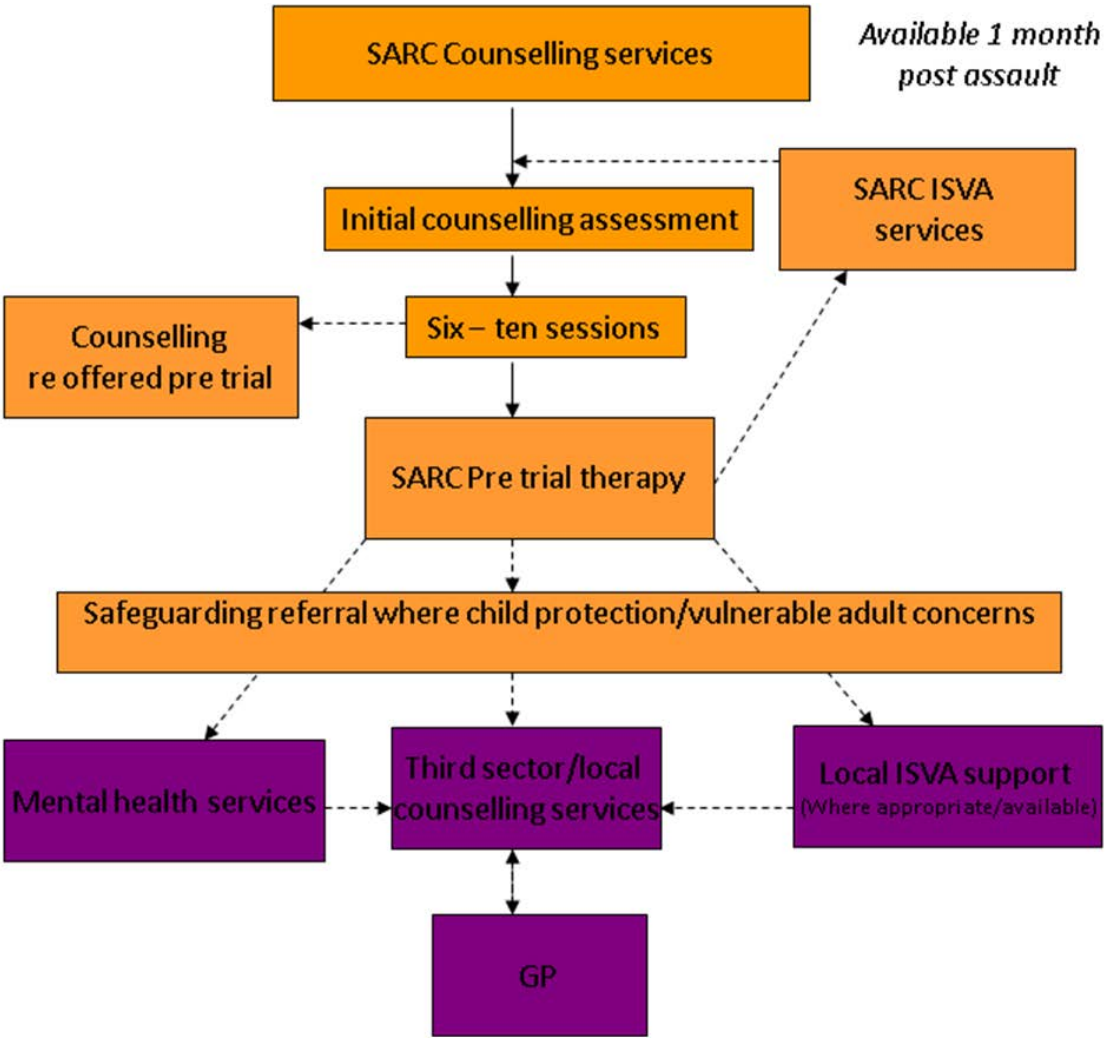
SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)



SARC Follow-up Adult Care Pathway (self-referral): SARC ISVA or SARC (as appropriate)- range of support services



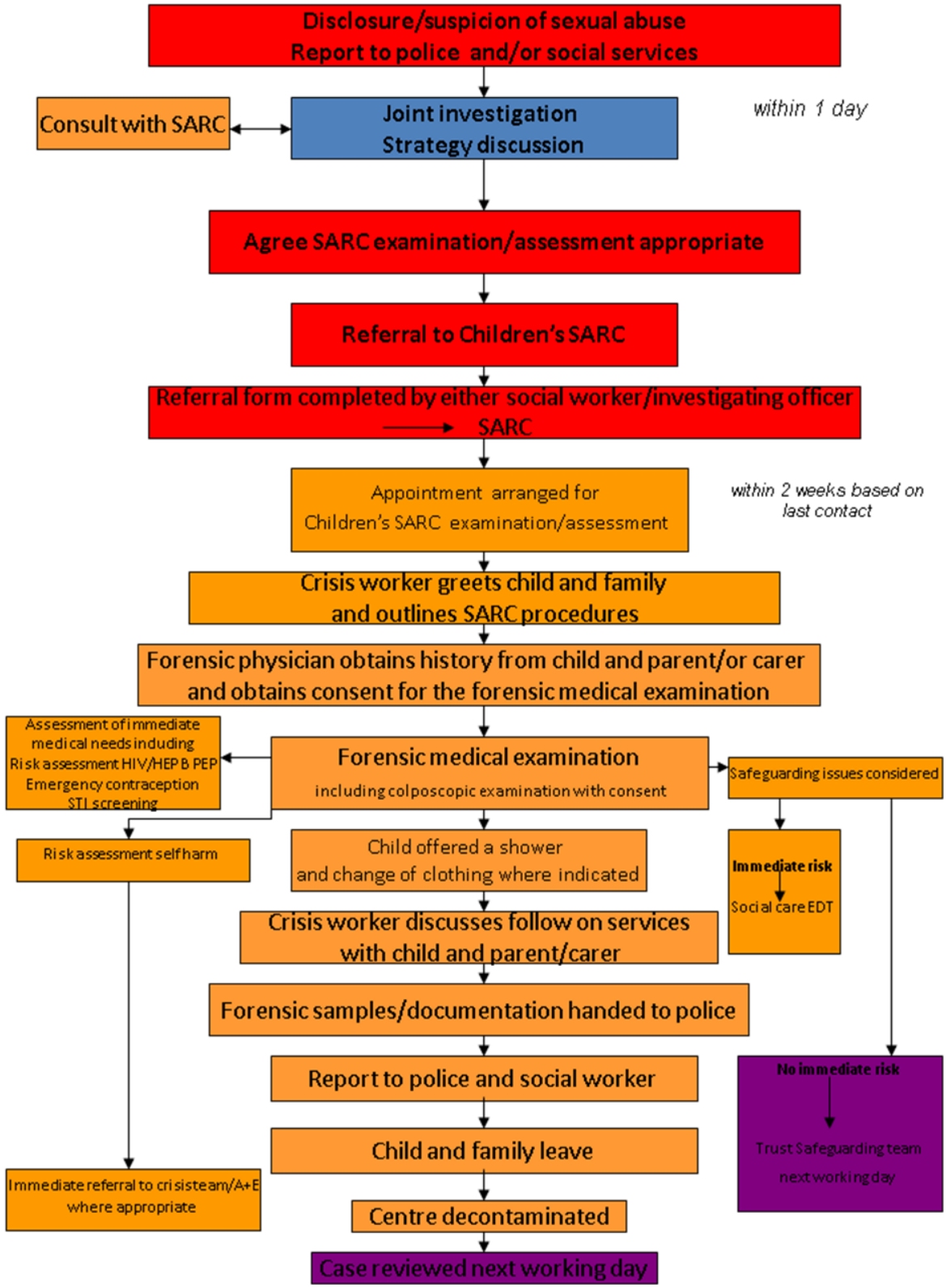
SARC Follow-up Adult Care Pathway (self-referral): Counselling services



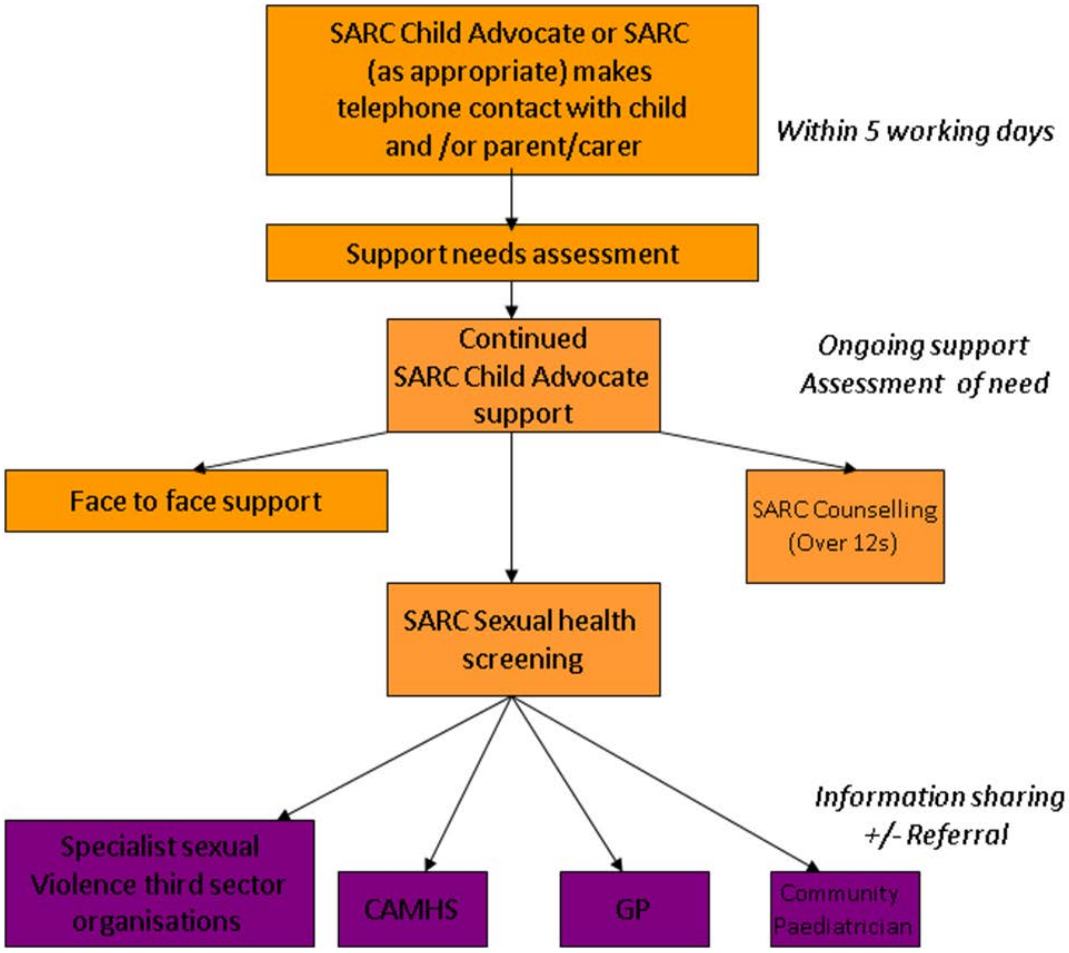
(*note:Third sector = Third sector specialist sexual violence services)

Appendix 2: Example Child and Young People Pathways

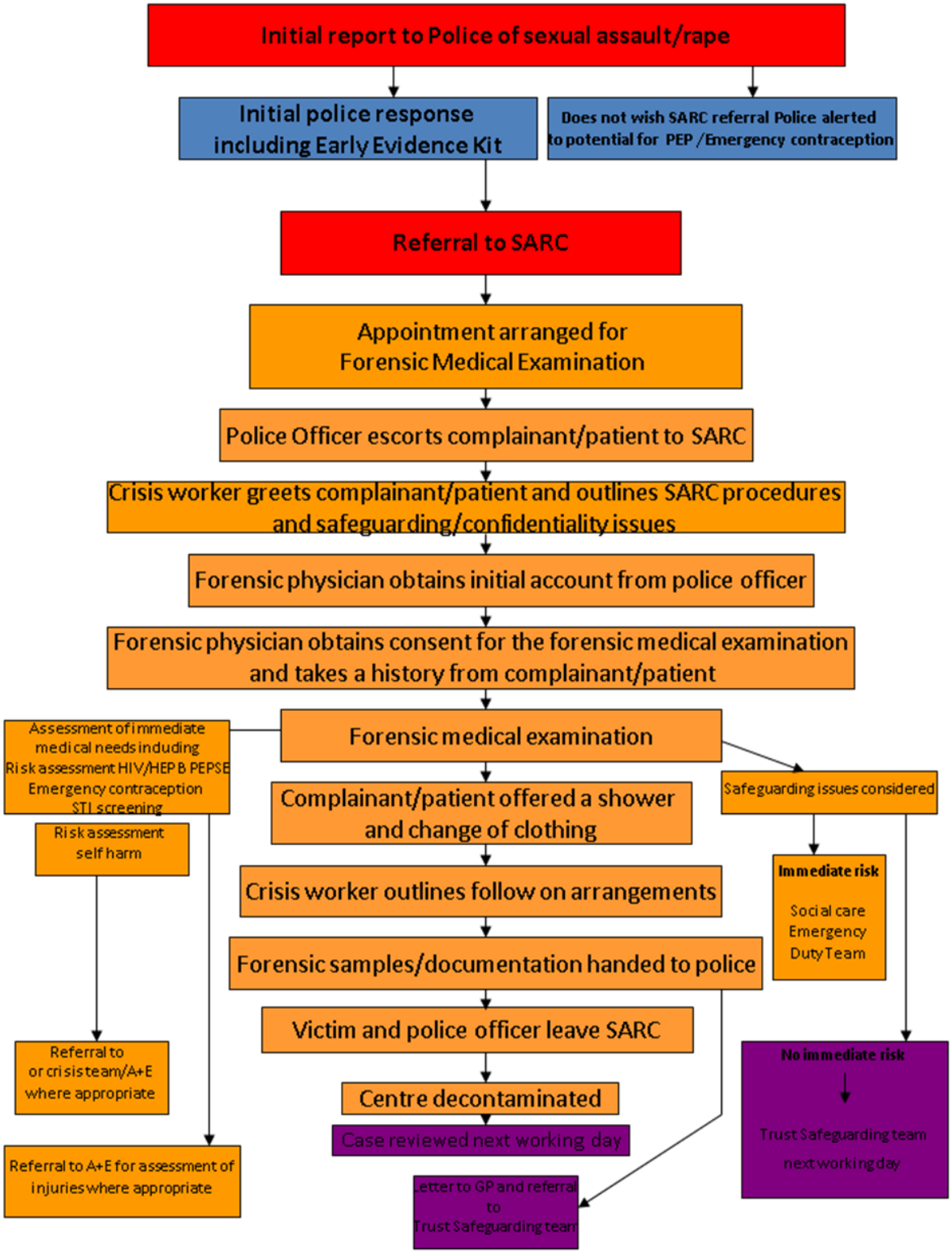
SARC Child Care Pathway (joint investigation): Initial attendance at SARC



SARC Follow-up Child Care Pathway (joint police/social investigation): SARC Child Advocate or SARC (as appropriate)

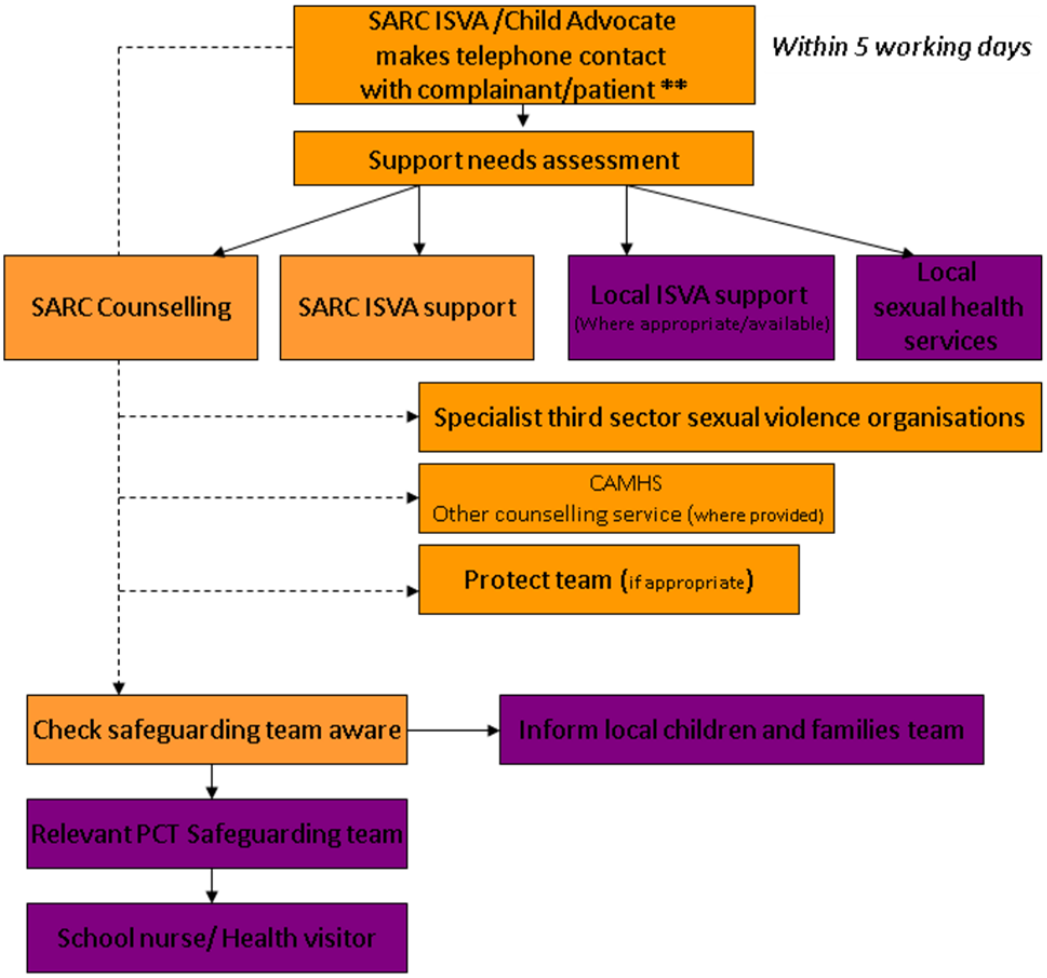


SARC Children and Young People Acute* Care Pathway (police case): Initial attendance at SARC



* *Acute- refers to one off sexual assault – forensically acute*

SARC Follow-up Children and Young People Acute* Care Pathway: SARC ISVA/Child Advocate/SARC (as appropriate)



*** Age appropriate*

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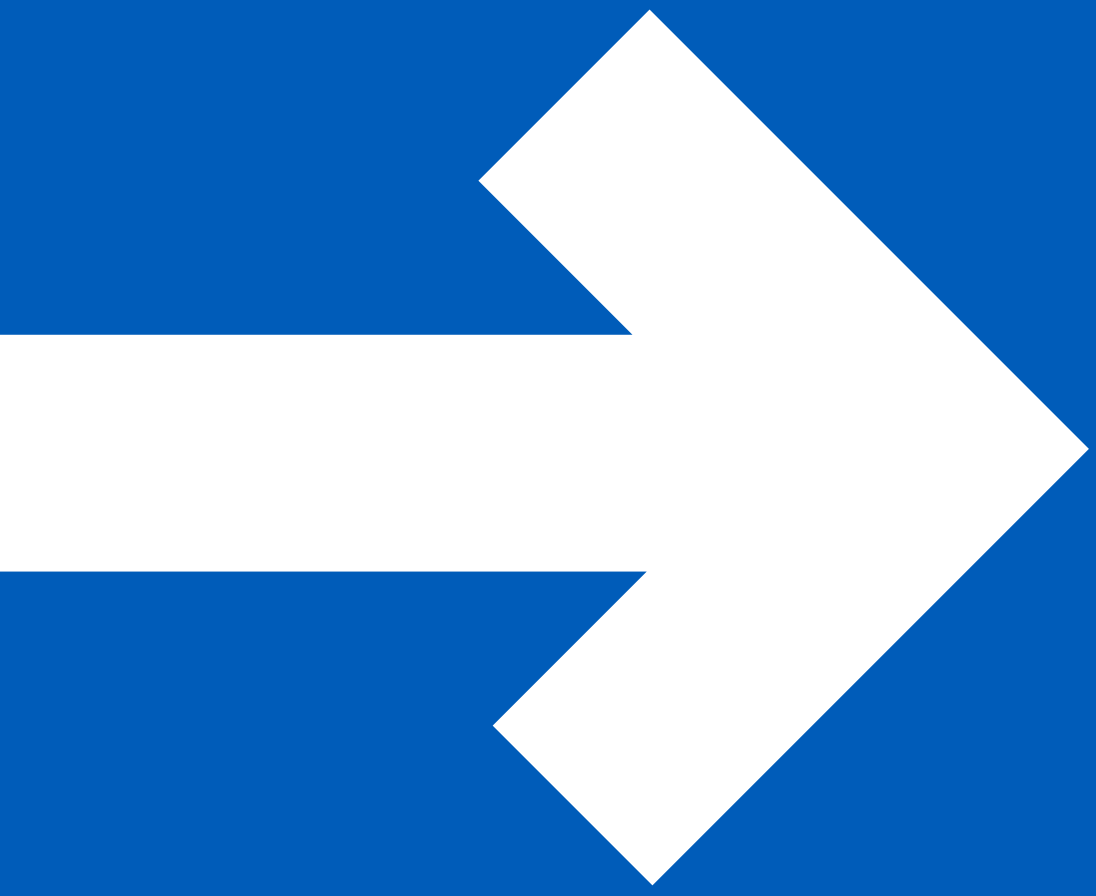
NHS England

STRATEGIC DIRECTION FOR SEXUAL ASSAULT AND ABUSE SERVICES

Lifelong care for victims and survivors: 2018 - 2023



NHS England Reader Information Box

Directorate

Medical	Operations and Information	Strategy and Innovation
Nursing	Transformation and Corporate Operations	
Finance	**Specialised Commissioning**	

Publications Gateway Reference: 07912

Document purpose:	Strategy
Document name:	Strategic direction for sexual assault and abuse services - Lifelong care for victims and survivors: 2018 - 2023
Author:	Health and Justice, Armed Forces and Sexual Assault Referral Centre (SARC) Team
Publication date:	12 April 2018
Target audience:	Survivors of sexual assault and abuse, survivor organisations within the third and charitable sector, Department of Health, Public Health England, Department of Health and Social Care, Directors of Public Health, Department for Education, Home Office, Ministry of Justice, National Police Chiefs Council, Association of Police and Crime Commissioners, Police and Crime Commissioners, Care Quality Commission, Local Government Association, Local Authority Commissioners, Clinical Commissioning Groups, Sustainability and Transformation Partnerships, and Integrated Care System Leads, providers of mental health care and providers of SARC services.
Additional circulation list:	All NHS staff
Description:	This strategic document outlines how services for victims and survivors of sexual assault and abuse, in all settings of the health and care system, need to evolve between now and 2023. It sets out six core priorities that NHS England will focus on to reduce inequalities experienced.
Cross ref:	N/A
Superseded docs: (if applicable)	N/A
Action required:	
Timing/deadlines: (if applicable)	
Contact details:	**Kate Davies**, Director of Health and Justice, Armed Forces and SARCs, Specialised Commissioning, NHS England, Skipton House, 80 London Road, London SE1 6LH

Document status:

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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in, access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Acknowledgment of thanks

We would like to thank the many people who have contributed to and supported the development of this strategic direction.

Particular thanks go to victims and survivors of sexual assault and abuse who have worked with us throughout a lengthy engagement phase and who have continued to work with us throughout its development. Many have supported our understanding of the impact of sexual assault and abuse by sharing with us their own experiences.

Thanks also go to our partners across the care and justice system; as well as commissioners and providers of sexual assault and abuse services.

These different groups have all welcomed the opportunity to work together to develop a vision for a pathway of care over a lifetime rather than services that are accessed at a particular point in time.

The voice of victims and survivors has been central to the development of this strategic direction for sexual assault and abuse services. We will continue our work with victims and survivors, their families and carers, as well as with our partners across the care and justice system, commissioners and providers of services across England, as we implement the priorities that we have set out.

Foreword

Professor Jane Cummings
Chief Nursing Officer,
NHS England

Sexual assault and abuse are serious crimes which continue to have a significant impact on our society. Their devastating consequences can often be misunderstood and neglected.

This strategic direction represents a shared vision and a shared focus for improvement. NHS England's strategic partners and most importantly, victims and survivors of sexual assault and abuse, have welcomed the opportunity to work together to consult on the co-development of a health and well-being focussed strategy, which takes into account a lifelong pathway of care for survivors and seeks to drive the improvement of services now and in years to come. It outlines how services need to evolve to ensure that as much as possible can be done to safeguard individuals and to support them at times of crisis and in particular, at the point of disclosure.

Over the past year, many cases of sexual assault have been brought to the forefront of the nation's attention. When looking at the historical Rotherham case in particular, I was astounded by the number of times these young victims were let down by multiple agencies.

Cases like this highlight that every staff member, with a duty of care, has their own role to play in providing support and protection. No one can have the option of saying 'it's the responsibility of someone else'.

Even though certain cases of sexual assault and abuse receive national media coverage, we must remember that the vast number of victims remain hidden. Far too many victims remain fearful of coming forward or lack faith in organisations.

I know that many organisations have significantly improved the way that they offer support to victims of sexual assault and abuse, but we can and must do more. The points raised in this very valuable document offer a framework of guidance in doing just that.

The strategic direction is focussed on six core priorities for delivery across England, which are set out below. Each priority recognises the complexity of health and wellbeing for lifelong care for victims and survivors of sexual abuse; and the fact that individuals may already be known to a number of services, even prior to disclosing. The priorities also recognise that to be effective at meeting short, medium and long term needs over the lifetime of a survivor, care needs to be trauma informed and considered as part of an integrated and whole system pathway of care and not an isolated segment.

THE SIX CORE PRIORITIES

- **Strengthening the approach to prevention**
- **Promoting safeguarding and the safety, protection and welfare of victims and survivors**
- **Involving victims and survivors in the development and improvement of services**
- **Introducing consistent quality standards**
- **Driving collaboration and reducing fragmentation**
- **Ensuring an appropriately trained workforce**

As we play our part in encouraging and empowering survivors of sexual assault and abuse to come forward, the demand on services will be even greater. By working in partnership, we can offer an effective and efficient service that places victims and survivors of sexual assault and abuse at the very centre, which in turn will enable us to offer the support and care when and where it is needed the most.

Professor Jane Cummings
Chief Nursing Officer for England

1. What is sexual assault and abuse and who is affected?

In the context of this document, references to sexual assault and sexual abuse include rape and sexual violence. Examples of offences or circumstances where offences may occur include (but are not restricted to):

- sexual acts involving a child, sexual harassment, forced marriage, honour-based violence, female genital mutilation, human trafficking, sexual exploitation and ritual abuse; or
- any unwanted sexual activity with someone without their consent or agreement.

Sexual assault and abuse can happen to anyone; men, women and children; at any age, and may be a one-off event or happen repeatedly. In some cases it can involve the use of technology such as the internet or social media which may be associated with grooming, online sexual harassment and trolling.

Sexual assault and abuse are two of the most serious and damaging crimes in our society.

Some factors can make particular groups of people more at risk of sexual assault and abuse[1]. These include people who:

- have a history of previous sexual abuse or who have experienced other forms of abuse
- have a disability
- are in care or who have a disrupted home life
- live without adequate supervision or who are isolated.

Risk factors can also vary depending on gender. Women are more likely to experience intimate partner violence if they have low education or exposure to their mother being abused by a partner[2].

Men are more likely than women to be subjected to institutional and clergy abuse as children, and prison-based sexual violence as adults[3].

The impact of any sexual assault or abuse is largely hidden and often not fully understood, with no identified effects that are unique to these crimes. It is well known, however, that the damage and devastation caused are enormous, extremely varied and often lifelong. They present in different ways for different individuals from different genders and demographics; the commonality being serious trauma and often compound trauma. Feelings of profound fear, terror and anxiety have been described by victims and survivors, with safety and trust being significant factors in the recovery process.

It can take many years for an individual to disclose sexual assault or abuse, particularly those people who have been abused or assaulted as a child, or those with a disability.

[1] NSPCC - who is affected by sexual abuse?;

Measuring the scale and changing nature of child sexual abuse and child sexual exploitation - scoping report, Professor Liz Kelly and Kairika Karsna, July 2017;

The impacts of rape and sexual assault; World Health Organisation: World report on violence and health, chapter six.

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[3] Heilpern, 1998; Mariner, 2001; John Jay College of Criminal Justice, 2004; Parkinson, Oates et al., 2009.

Some facts and figures

- In the year ending September 2017, police recorded 138,045 sexual offences, the highest figure recorded since the introduction of the National Crime Recording Standard in 2002 and a 23 per cent increase on the previous year[4].
- Around two per cent of adults aged 16-59 were victims of sexual assaults in the year ending March 2017[5].
- It is estimated that up to 80 per cent of incidents are unreported and as few as 28 per cent of victims report their experience to the police[6].
- More than a third of rape victims and half of female victims of other sexual offences, including assaults, grooming and sexual exploitation, are under the age of 16. Girls aged 10 to 14 are most likely to be the victims of reported rape[7].
- Male sexual violation is one of the most under-reported crimes worldwide. The Ministry of Justice estimates that around one in ten victims of rape and attempted rape each year are male[8].

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2. The case for change

Heightened profile

Over recent years, the profile of sexual offences has been raised significantly due to the Children's Commissioner's Inquiry into Child Sexual Exploitation in the family environment, the Independent Inquiry into Child Sexual Abuse (IICSA)[9], the independent inquiry into child sexual exploitation in Rotherham, the various cases involving well-known individuals and, most recently, the emerging cases associated with football. This is likely to have an impact on the uptake of mainstream services, and in particular, mental health services for non-recent victims and survivors of sexual assault and abuse.

The needs of victims and survivors

Victims and survivors tell us that, both before and after disclosure, they frequently find it difficult to navigate a confusing and disjointed array of services at the time when they need them most and at times when they are often in crisis. They also tell us that their experience can be compounded both by difficulties in knowing which services to access to get the help and support that they need, and by inconsistencies in the quality of care that they receive once they do access services. This heightens the risk of compound trauma that can occur as a result of repetitive, prolonged and sustained abuse and/or re-traumatisation, which is the reminder of a past experience resulting in re-experiencing the initial trauma. Heightening the risk further, disclosure and identification of sexual assault and abuse often takes place within a criminal justice setting rather than within a service dedicated to the care and support of victims and survivors.

This can often mean that, whilst support through the forensic and judicial process is available, there may be little emotional and physical support longer-term and over the individual's lifetime.

Victims and survivors of sexual assault and abuse have urged us to collaborate and to integrate services across the health, care and justice sectors to ensure that transition from one service into another is streamlined. They want us to focus on the quality and continuity of care and provide more joined up support for individuals, as well as for their families and carers. This includes improved information-sharing and communication between NHS and third sector organisations, as well as better referral pathways to ensure that victims and survivors are directed to the most appropriate service at the right time in their journey to recovery.

A complex system

The landscape for sexual assault and abuse services is wide and complex. It spans a number of different systems and government organisations, including health, care and justice, and requires them to work together. The commissioners of services are varied, and there is a wide range of providers, including some specialist and third sector organisations. This creates a significant challenge, and all the different bodies can find it difficult to work together effectively to meet the lifelong needs of victims and survivors. This can result in fragmentation in service delivery, frustration and poor outcomes for victims and survivors of sexual assault and abuse over their lifetime.

[9] Independent inquiry into child sexual abuse.

3. Our vision

Our vision is to radically improve access to services for victims and survivors of sexual assault and abuse and support them to recover, heal and rebuild their lives. Our vision is in two parts:

- Firstly, for those who have experienced recent sexual assault and abuse and who are in the immediate aftermath, we must provide highly responsive, personal services delivered by trained doctors, nurses and support workers in settings that respect privacy and that are easy to access. These services should include specialist medical and forensic examinations, practical and emotional support and support through the judicial process.
- Secondly, for those who have experienced historic sexual assault and abuse, we must provide therapeutic care that recognises the devastating and lifelong consequences on mental health and physical and emotional wellbeing.

Underpinning both parts is the need for all commissioners and providers of services that support victims and survivors of sexual assault and abuse to work together to create a seamless approach that recognises individual needs and reduces fragmentation and gaps between services.

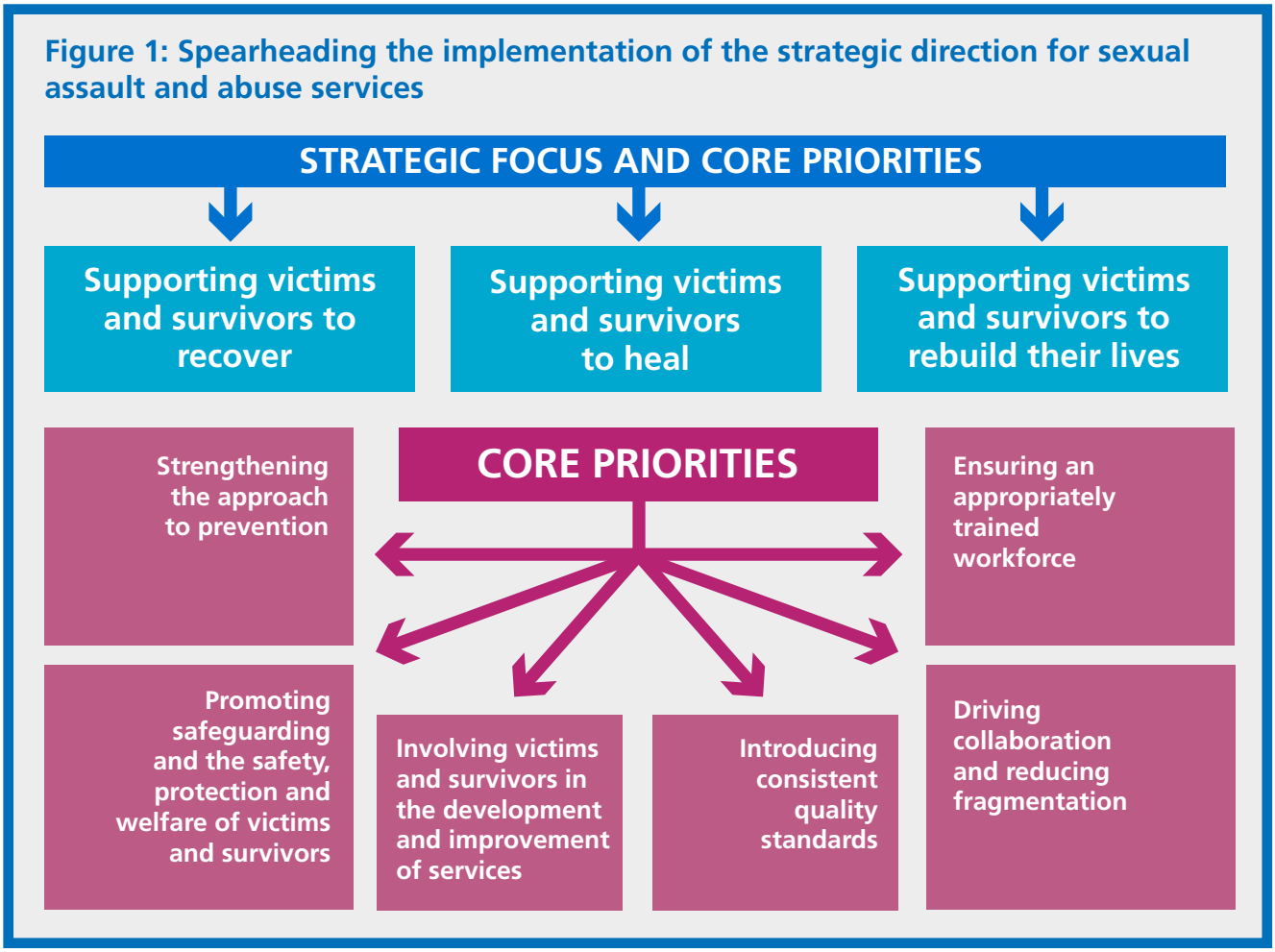
Our aim is therefore to improve health outcomes for victims and survivors of sexual assault and abuse.

4. Our strategy for improving sexual assault and abuse services

This chapter sets out our strategy for how we can improve the whole pathway of care for victims and survivors of sexual assault and abuse over a lifetime. Our strategy has been informed by an extensive period of engagement with strategic partners, providers, commissioners, victims, survivors from diverse communities and in some cases their families and carers, as well as the extensive evidence base.

Our approach is based around six core priorities, as figure 1 illustrates. This chapter explains what we will do to implement each of these priorities, and what difference implementation of each of the priorities will make.

Figure 1: Spearheading the implementation of the strategic direction for sexual assault and abuse services



Strengthening the approach to prevention

Preventing sexual assault and abuse from happening at all should be paramount and, for victims and survivors of previous incidents, reducing the risk of future re-victimisation is central to their recovery, healing, ability to rebuild their lives and ongoing safety.

Prevention is becoming more and more challenging[10,11]. Many parents may find it difficult to talk to their children about the risks of sexual assault and abuse. Behaviours amongst adolescents are changing, particularly their understanding of healthy relationships, and it is also becoming more difficult to teach younger children how to keep themselves safe on social media and speak out if they need to.

The internet in particular has transformed the nature of sexual assault and abuse and the risks around sexual exploitation and harmful sexual behaviour. 'Sexting' and other age-inappropriate sexual behaviour, such as watching extreme pornography or making inappropriate remarks, have also become more commonplace.

The way children and young people use technology and social media can make them more vulnerable to sexual exploitation online. The charity Barnardo's suggests that children and young people at risk of online sexual abuse may be younger than those who experience other types of sexual exploitation and may not fit into standard definitions of 'vulnerable'.

There are other groups which may find it difficult to report sexual assault and abuse. This suggests that we need to focus our prevention efforts. This includes the lesbian, gay, bisexual and transgender (LGBT) communities, the black and minority ethnic communities, those with learning disabilities and sex workers, as well as all age groups within the prison population[12].

Every organisation involved in the delivery of sexual assault and abuse services has a responsibility to help stop these crimes from happening. Services across the whole pathway need to work in partnership to assess proactively, the risk amongst vulnerable groups, as well as previous victims and survivors, and to take action to minimise their exposure to harm.

[10] NSPCC: Preventing Child Sexual Abuse: Towards a National Strategy for England, 2015, Jon Brown and Aliya Saied-Tessier.

[11] Over the Internet, Under the Radar: Prevention of Online Child Sexual Abuse and Exploitation in Scotland, February 2017, Centre for Youth & Criminal Justice.

[12] Supporting LGBTI survivors of sexual violence, Rape Crisis Scotland, 2014; Between the Lines: Service Responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence, 2015, Dr. Ravi K. Thiara, Sumanta Roy and Dr. Patricia Ng; 'Many women of colour don't go to the police after sexual assault for a reason' news article; Behind closed doors. Preventing sexual abuse against adults with a learning disability, September 2001 page 6; Female sex workers, 2018; Male sex workers, 2017; Howard League for Penal Reform: Coercive sex in prison: briefing paper by the commission on sex in prison, 2014.

To achieve this, we will:

- implement recently-published guidance from the National Institute for Health and Care Excellence on what is known as harmful sexual behaviour. The guidance focusses on children and young people who carry out harmful sexual activities, directed either towards themselves or others[13]. In order to make sure that effective implementation happens, we will:
  - ensure that the guidance reaches the relevant NHS England commissioned services
  - undertake discussions with the national Sexual Assault Referral Centre (SARC) Clinical Forum around the appropriateness of developing specific care pathways for children and young people who display harmful sexual behaviours
  - work with partner organisations to input health expertise into the development of their interventions
  - work with NHS England's SARC Clinical Forum and Lived Experience Group to support an improvement in access to services by developing and sharing information which raises awareness of service availability
  - collaborate with the Home Office, as they implement their Disrespect Nobody campaign and refresh their Violence Against Women and Girls (VAWG) strategy to make sure that they are reflected within NHS commissioning plans
- work with the police to:
  - develop a prevention plan aimed at vulnerable groups. This will focus on awareness raising and education, and will include the development of a National Intelligence Model profile by the police for the sexual assault and abuse of children, young people and adults
  - increase awareness of the services provided by SARCs, particularly through the LGBT communities, BME communities and vulnerable women's centres
  - develop easy-read information on the role of a SARC for people with learning disabilities.

[13] Harmful sexual behaviour among children and young people guidance from NICE (National Institute for Health and Care Excellence), September 2016.

CASE STUDY

During a session being delivered by a third sector organisation, to a group of year 10 students on healthy relationships and consent, a 14 year old girl became distressed and upset. She spoke privately to one of the staff and went on to disclose that she was being sexually assaulted and raped by an older cousin and had been since the age of 11.

Guilt and shame had prevented her from telling anyone before. She was worried that it was her fault because she had never said no or told him to stop and it had happened on more than one occasion. She was also worried about getting into trouble for under age sex.

She was given immediate support; the school's designated safeguarding lead was engaged and given support to tell her parents. She was signposted to further help and support and was able to talk about the risks around future safeguarding and prevention.

She later self-referred for counselling and Independent Sexual Violence Advisor (ISVA) support and was given help in terms of understanding her choices regarding the judicial process.

She remained in counselling for a year, which helped her to process and overcome the trauma she had experienced.

She continues to attend school and understands the importance of healthy relationships.

CASE STUDY

A 53 year old male was sexually abused as a teenager. His experience was complex and traumatic and occurred at a developmentally sensitive stage in his own life.

He has a long history of depression, anxiety and anger issues and an inability to express emotion, as well as experiencing chronic feelings of shame, guilt and self-blame. He also has a conviction for a non-contact, online sexual offence.

For years, he was unable to disclose or speak about his experience as a victim and certainly his involvement as a perpetrator.

As part of his need to recover and 'change', he accessed a psychotherapy-based prevention programme and completed 23 sessions.

For survivors of sexual assault and abuse, psychotherapy highlights and educates individuals and communities on the destructive impacts of sexual assault and abuse; and for survivors who have sexually offended, the delivery of trauma-informed psychotherapy addresses the offender's trauma with the aim of reducing offending.

Promoting safeguarding and the safety, protection and welfare of victims and survivors

The responsibility to prevent sexual assault and abuse also includes a responsibility to safeguard those who we know to be particularly vulnerable and those who are placed in the care of others. Supporting this responsibility is the Health and Social Care Act 2012, Working Together to Safeguard Children (2015) which is currently under review with an updated version expected in 2018, the Children Act (2004) and supporting vulnerable adults, the Care Act (2014).

Safeguarding is by far the most effective way to protect children, young people and vulnerable adults against any form of harm, abuse and neglect, and safeguarding the individuals that engage with them should be a priority for all providers of services.

Across all organisations that have a caring responsibility for vulnerable adults, children and young people, measures should be in place to ensure that any suspicion of sexual assault or abuse is investigated and acted upon. If safeguarding measures are not assured, and vulnerable adults, children and young people are not safeguarded, the risks of sexual assault and abuse become higher. For victims and survivors of sexual assault and abuse, in particular, the risk of re-victimisation and re-traumatisation become significantly greater, to the detriment of their health and wellbeing. This is particularly relevant for individuals in their teenage years. Early identification of any form of sexual assault and abuse is therefore fundamental to any health outcome.

Particular consideration should be given to safeguarding those whose circumstances make it difficult to report their sexual assault or abuse and who may feel reluctant to make a disclosure. For instance, those whose immigration status is uncertain, who have minor criminal offences, those who are misusing substances, those with a specific language barrier and in particular, those whose families are carers or have been involved in any assault or abuse that has taken or is taking place.

Making a commitment to safeguard individuals also means that statutory and specialist third sector organisations must work together at both strategic and operational levels. Joined-up, collaborative working (see page 20) is paramount.

To achieve this, we will:

- develop and use commissioning frameworks that explicitly describe what safeguarding means for victims and survivors of sexual assault and abuse, define responsibilities and clarify what is expected of providers of services
- improve information sharing by supporting the Child Protection Information Sharing (CPIS) programme which aims to ensure that 80% of unscheduled care settings are signed up to the CPIS protocol by 2019. This will allow service providers to understand if a child or young person is already known to services.

CASE STUDY

A mother of two teenagers has been supporting the eldest following rape by a stranger five years ago when she was 13.

The trauma which followed led to her daughter's withdrawal from school, attempted suicide and several episodes of care in a mental health unit.

Initially, the mother felt that she received little support to help her communicate with her daughter. As a result, she was interacting with her daughter without being guided as to what might help, hinder or even cause further damage to her daughter's already fragile state.

The mother attended counselling which began to have a positive impact on how she was able to behave and communicate with her daughter. Over time, she was able to start giving her daughter more freedom and was able to begin to 'let go'.

Her daughter has now started to re-build her life with appropriate support from her mother and is able to go out and socialise independently.

Involving victims and survivors in the development and improvement of services

Victims, survivors and advocacy organisations are the most important voices in service re-design and development in terms of their ability and power to help others to recognise and to understand the scale, complexity and impact of sexual violation.

Involving survivors and advocacy organisations in the improvement and development of services, offers an opportunity for them to be heard without judgement or stigmatisation. It is vital that we use their expertise to influence service improvement through direct experience.

When involving victims and survivors in the development and improvement of services, it is important to consider a range of options to involve people. For example, engaging with men may need a different approach to that used to engage with women and likewise for children and younger people.

To achieve this, we will:

- develop, publish and circulate a set of principles to govern the involvement of survivors and survivors' advocates in the commissioning and delivery of sexual assault and abuse services. These principles will build upon NHS England's 'What Works' publication and will be developed jointly with the wide range of stakeholders who have helped us to develop this strategy. They will be circulated to all organisations that commission or provide services which support victims and survivors of sexual assault and abuse.
- establish a national victims' and survivors' voices group, managed by NHS England. This group will help to ensure that ongoing service developments are informed by lived experience and will help to hold services to account for the actions described in this strategy.

CASE STUDY

A mother of a 15 year old girl with learning disabilities who had been sexually abused was referred by her GP to the local Improving Access to Psychological Therapies (IAPT) programme.

In the assessment session, the mother disclosed that she herself had been subject to sexual abuse at the age of 14. This disclosure triggered contact from the police which was unexpected, as she had not been involved in a decision to contact them. It also triggered an unexpected concern over the safety of her daughter.

The mother immediately lost trust in health professionals and has not accessed the IAPT service since. She feels that she should have been involved in any decision to involve the police and been included in any discussion regarding any perceived or potential safeguarding risks.

Introducing consistent quality standards

Victims and survivors of sexual assault and abuse describe significant variation in the quality of service they experience when trying to access support. When they do receive support, some feel that their needs are poorly recognised and, for some victims and survivors, it has taken multiple attempts over many years to get the help, care and support that they need. This is made considerably harder at times when individuals are experiencing significant trauma and are in severe crisis.

The delivery of good quality, consistent care to victims and survivors of sexual assault and abuse is paramount to their ability to recover, heal and rebuild their lives. Regardless of the part of the country in which they are accessing services and regardless of their gender, ethnicity, sexual orientation, age and relationship with the criminal justice system, the standard and quality of care should be the same.

Any standards should particularly support those people with disabilities, as they will often face additional difficulties in attempting to access support. They may already be socially isolated because of their disability and may find it difficult to disclose as they may have no opportunity to seek help without their abuser being present. Victims and survivors with a specific language barrier and, in particular, those who rely on sign language, may also face additional difficulties in accessing support.

Consistent quality standards are also important in paediatric services to ensure that we can meet the complex needs of child victims. The paediatric model requires mechanisms that ensure timely and easy access and structured, seamless referral into clinical commissioning group (CCG) commissioned child and adolescent mental health services and other specialist support. For example paediatric genito-urinary medicine (GUM) services for children under the age of 13 and services provided by the third sector to ensure access to appropriate assessment, treatment and ongoing specialist care. Structured and seamless transition from paediatric services into adult services should be included as part of the standards.

A set of standards will not only help us to drive up quality, but also measure our success and understand whether we are doing the right thing, at the right time, to achieve the best possible results for victims and survivors.

To achieve this, we will:

- work with organisations across the health, care and justice sectors, as well as victims and survivors, to develop a set of quality standards that:
  - supports delivery of the best possible outcomes for individuals accessing services and care
  - sets a clear expectation that care is compassionate, sensitive and delivered in a non-judgemental manner and is centred around the needs of the victim or survivor
  - is underpinned by a strong governance and accountability framework that is clear about the role of each organisation within the system and what is expected of them

  - provides a framework against which to measure and evaluate the quality of care, identify gaps, support future goal setting and a cycle of continuous improvement
  - informs future policy and commissioning decisions
  - supports the criminal justice process
  - reflects interdependencies across the health, social care and criminal justice systems
- revise existing service specifications to include specific quality standards, reduce variation and highlight interdependencies with other services such as:
  - adult and paediatric services
  - therapeutic support
  - educational, training and clinical requirements
  - leadership and governance arrangements.
- work with the Care Quality Commission (CQC) to ensure that their programme of SARC inspections, due to commence in 2018, is based on a strong, person-focused inspection regime that examines the wider pathways of care for sexual assault and abuse
- work with other commissioners to ensure that interdependencies throughout pathways of care are reflected in the associated service specifications, in particular around access to:
  - paediatrics, including GUM services for children under the age of 13
  - specialist mental health services which children, young people and adults can access.

CASE STUDY

Following a successful pilot, a quality assurance programme took place across London's three SARCs and later across the four SARCs in Kent, Surrey and Sussex.

Associated quality standards were developed based on the national service specification (commonly known as Specification 30) and reframed to reflect the five CQC domains (safe, caring, effective, responsive and well-led).

By introducing quality standards, it has supported an enhanced service for adults and children and young people's services:

- The Havens SARCs are delivering the first UK service, which is based on child house principles, incorporating early intervention, psychological therapy for children and young people, and sexual assault victims, as well as police involvement. Achieving Best Evidence interviews are being conducted by clinical psychologists in a safe and therapeutic environment.
- Kent, Surrey and Sussex have brought together the Crown Prosecution Service, the three police services and the four SARCs to develop a regional Forensic Improvement Plan.

The quality assurance process has also identified best practice associated with care for children with a learning disability.

For example: In the South (Brighton and Sussex), staff worked closely with the family and support staff of a child before she came in for a medical examination following an assault. The family were sent photos of the room she would be examined in and information about what to expect to help prepare the child. The service always requests a health passport in advance and has a robust relationship with the appropriate third sector agency to ensure additional support is in place if required, particularly where the child's language and communication skills may be limited.

Driving collaboration and reducing fragmentation

Victims and survivors of sexual assault and abuse tell us that their experience of moving between the health, social care and criminal justice systems is fragmented and that services can be difficult to navigate. This strategic direction sets out how a joined-up approach to the commissioning and provision of services is vital if we are to provide people with the right support at the right time. Victims and survivors, along with their information, should flow seamlessly between the different services, including those provided by specialist third sector organisations, without complication and over their lifetime. Without this collaboration, we run the risk that limited access to support services and therapeutic provision; high thresholds and long waiting lists will harm the recovery of victims and survivors.

Delivery of joined-up care needs to recognise the highly varied needs of individuals. Victims and survivors will need different levels of care and different types of support at different times in their lives and this will be dependent on their circumstances, the pace of their recovery and the level of expertise and support received at the point of disclosure. Unlike some other services, the commissioning and provision of services supporting those who have been sexually assaulted or abused cannot be channelled through a linear pathway of care. Prior to disclosure, a number of different service providers may have been involved in an individual's care and support. For example, as a direct result of negative behaviours, such as drug or alcohol dependency, self-harm, sexual risk taking and some criminal behaviours, victims and survivors may already be known to specialist and community mental health teams or crisis support services, as well as addiction, community sexual health or educational support teams, social services or the criminal justice system.

Collaboration and a reduction in fragmentation should underpin the delivery of all priorities set out within this strategic direction and in particular, should form part of the quality standards for sexual assault and abuse.

To achieve this, we will:

- ask all organisations that commission or deliver services to sign up to a new governance framework that explicitly outlines the outcomes that they are expected to achieve and how they will report those outcomes. This will be done through the Sexual Assault and Abuse Services (SAAS) Partnership Board, which includes representation from national, regional and local commissioners, including Accountable Care Organisations, Sustainability and Transformation Partnerships, CCGs, local authorities, Police and Crime Commissioners and voluntary sector organisations
- ensure the commissioning of services is trauma informed. This will be done by ensuring that service specifications and tenders recognise and encourage the links between the trauma victims and survivors of sexual assault and abuse experience and mental health, as well as the benefits of the principles of integrated child house type models
- improve information sharing between regional teams around procurement opportunities in order to ensure the best response from the market.

CASE STUDY

A 43 year old male was sexually abused as a teenager and remained silent until the age of 40.

He has a long history of drug and alcohol misuse, deliberate self-harm and three significant suicide attempts. He is well known to health care service providers and has once been sectioned under the Mental Health Act.

He had been offered help and support before, but first engaged in specialised sexual violence support following a discussion with his GP. This led to a referral to access 'drop in' services and later therapeutic services.

Whilst engaging in therapeutic services, his psychiatrist changed, as did the advice that he was given regarding continuation with therapeutic services. This change agitated his issues with trust and abandonment and may have contributed to a fourth suicide attempt.

Knowing of his engagement with the service providing specialist sexual violence support and the impact it was having, his GP requested their assistance in re-establishing his care pathway by instigating a multi-disciplinary care planning meeting.

Multi-agency planning and support contributed to safeguarding the individual, ensuring his wider needs were met and that he continued to commit to his pathway of care and engage with service providers.

Ensuring an appropriately trained workforce

The trauma that victims and survivors of sexual assault and abuse experience manifests in many ways: disrupting health and development, adversely affecting relationships and contributing to significant mental health issues. A trauma-informed approach to care links trauma and mental health by recognising its effects and human response. It emphasises the need for physical, psychological and emotional safety and helps survivors to recover, heal and rebuild a sense of control and empowerment.

In order to help and support victims and survivors of sexual assault and abuse who may be experiencing complex trauma and re-traumatisation and achieve the best outcome, it is important that those with whom they come into contact at any given point in their journey to recovery are appropriately trained and are aware of the effects and manifestations of sexual assault and abuse.

At the point of disclosure and identification of sexual assault and abuse, for example, victims and survivors will often be in severe crisis. It is important that first responders understand how to act and can provide a consistent level of service to the individual making the disclosure[14]. Initial disclosure may happen within a criminal justice setting where there may be support and expertise available. However, disclosure and consequent care will unavoidably take place in mainstream services where, we are told, the same level of awareness, knowledge and expertise may not be present.

Examples of mainstream services could include, but are not exclusive to, maternity, gynaecology, infertility, community sexual health, teenage pregnancy and gender reassignment services.

Wherever disclosure takes place, many victims and survivors of sexual assault and abuse describe feeling let down and disappointed when seeking the help they need. They describe delays in being able to access initial help and support and suggest that, when they do, many professionals across the health and social care system have an inadequate understanding of and empathy for sexual assault and abuse and often fail to link behaviour and symptoms to the underlying trauma. In some cases, we are told that service providers can fail to recognise men and boys as victims of sexual assault and abuse, rape and sexual exploitation, which further increases their vulnerability.

Victims and survivors also tell us that, once a disclosure has been made, there can be a lack of knowledge amongst service providers about where to seek the specialist support required, and a lack of support for onward referral. Given the likelihood that victims and survivors could still be in or facing crisis, there is a risk of dual diagnosis such as depression and anxiety disorders and mis-diagnosis of dissociative disorders, such as Post Traumatic Stress Disorder (PTSD) and Attention Deficit Disorder (ADHD).

[14] Report of the independent review into the investigation and prosecution of rape in London, Rt Hon Dame Elish Angiolini DBE QC (April 2015).

When supporting and caring for victims and survivors of sexual assault and abuse, professionals need to ensure that they display an appropriate understanding of and empathy for its impact on both men and women. When this fails to happen, it can exacerbate the burden of victim and survivor shame and unnecessarily prolong the length of time that it takes to access the right support. This can have a significant impact on diagnosis, recovery and trust.

To achieve best outcomes for victims and survivors, it is essential that awareness of the impact of sexual assault and abuse is raised across the whole workforce in order to minimise the risk of re-traumatisation and any unanticipated trauma and ensure that care and support are delivered at each stage of an individual's journey to recovery.

We hope that, by improving awareness and training across the workforce, victims and survivors will be better able to access specialised services, safeguarding will be enhanced, the quality of care received improved and ultimately patient experience and outcomes heightened.

To achieve this, we will:

- include workforce requirements in the quality standards (page 18). This should cover training needs and guidance on optimal skill mix
- set out workforce requirements within the quality standards, identify training needs against quality standards and work with commissioners to ensure that they have plans for meeting any gaps
- require all providers to develop workforce plans, which include a process for developing skills and competencies to the national standards
- ask the newly established SARC Clinical Forum to adopt 'workforce' as one of its key work streams
- work with therapeutic providers, including the specialist voluntary sector, to develop guidance on delivering trauma-informed services aligned to the Crown Prosecution Service provision of pre-trial therapy guidance.

CASE STUDY

A 40 year old female was abused between the age of five and 16.

In her late teens she developed obsessive-compulsive disorder (OCD) which took over her life, and also suffered depression and anxiety.

She accessed her GP and made a disclosure about her abuse. Whist her GP was sympathetic, she was told that therapy often left people in pieces; so she decided not to bother.

A few years later, she found the courage to call a women's centre, which dealt with physical and sexual abuse. The person that she spoke to was dismissive and so she decided not to seek help again.

Later still, she saw another GP who referred her for specialist counselling and she has since accessed a ten week group course for adult survivors of sexual abuse.

She states that, based on her experience, health professionals and society need more awareness of sexual abuse and its impact, both to prevent it happening and to encourage survivors of all ages to cast aside misplaced shame and come forward to receive help.

CASE STUDY

A 20 year old male with a hearing impairment experienced sexual abuse as a child. As an adult he suffered flashbacks, night terrors and depression. He disclosed to his GP as an adult.

He was referred to a counsellor who engaged the services of a British Sign Language (BSL) interpreter. However, as neither the counsellor nor the interpreter had specialist understanding of sexual assault and abuse and as BSL is a visual language, the experience became too traumatic.

A partnership has since formed between a supporting third sector organisation, BSL and a specialist in the health of the deaf community. The ambition of the partnership is to create a greater understanding of the needs of hearing impaired survivors of sexual assault and abuse and increase communication models for BSL signers and interpreters to ensure that any risk of re-traumatisation through sign is limited.

5. Delivering the strategic direction for sexual assault and abuse services

Across some parts of the country, there are already services for victims and survivors of sexual assault and abuse that are taking positive steps to work collaboratively and improve quality. Driven by the ambition set out in this strategic direction, we need to ensure that good practice is shared and a cycle of continuous improvement is embedded, so that service delivery is consistent and variation reduced throughout England.

If we are successful, we believe this will deliver:

- better health outcomes for victims and survivors
- greater value for money; and
- a reduction in:
  - emergency department attendances
  - GP visits
  - recidivism of survivors as offenders (both non-sexual and sexual offending).

Government departments and national and local organisations with responsibility for commissioning these services, need to ensure that existing and newly commissioned services are developed and delivered in line with this strategic direction and with the new quality standards for sexual assault and abuse services. A significant number of these services are delivered by the third sector and the same high standards must apply.

This is a five year strategy and its delivery will be supported by a detailed delivery plan which will be published later on this year.

We will monitor progress through established governance mechanisms, primarily NHS England's Health and Justice Oversight Group and the Sexual Assault and Abuse Services Partnership Board. We will use the new, national victims' and survivors' voices group (page 17) to hold these groups to account for delivery. Progress will be ascertained by self-assessment against the quality standards with an accompanying verification process alongside findings from the CQC's inspection process, which is due to commence during 2018. We will publish further details of this process when we publish the quality standards.

Throughout its duration and by taking the action proposed, we expect to see a significant improvement in a number of areas across the health, care and criminal justice systems.

In particular and through action taken which is supported by the information gathered through the proposed gap analysis, self-assessment against quality standards and the result of CQC inspections, we expect to see service delivery and victim and survivor experience and outcomes improve.

Annexe 1: Commissioning responsibilities

Commissioning responsibility	Service
NHS England	• Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police • Child and adolescent mental health services Tier 4 (CAMHS Tier 4) • Contraception provided as an additional service under the GP contract • HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE)) • Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs • Sexual health elements of prison and Immigration Removal Centre health services • Cervical screening • Specialist foetal medicine services
Clinical commissioning groups	• Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of victims and survivors of sexual assault and abuse, including the third sector • Most abortion services • Sterilisation • Vasectomy • Non-sexual health elements of psychosexual health services • Gynaecology, including any use of contraception for non-contraceptive purposes • Secondary care services, including A&E • NHS 111 • Sexual health services for children and young people including paediatric care/support • Specialist voluntary sector services (in some areas) • Ambulance/blue light services
Police and Crime Commissioners	• Specific commissioning responsibilities for victims, including victims of sexual assault and abuse • Specialist voluntary sector services • Police 101 • In some forces, the police lead on the procurement of SARC services
Local authorities	• Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care) • STI testing and treatment, chlamydia screening and HIV testing • Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention, sexual health promotion and services in schools, colleges and pharmacies • Specialist voluntary sector services
Ministry of Justice	• National Male Survivor helpline • Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over
Home Office	• National services for victims of child sexual abuse

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact **0300 311 2233** or e-mail **england.contactus@nhs.net** stating that this document is owned by the Health & Justice, Armed Forces and Sexual Assault Referral Centre (SARC) Team, Specialised Commissioning Directorate.

Legal guidance for NHS commissioners on equality and health inequalities duties is available at: https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/

Sexual Violence Needs Assessment for Avon and Somerset

Introduction and key findings

The Bristol Sexual Violence Services Consortium have produced a sexual violence needs assessment for Avon and Somerset. It has been produced by Jennifer McMahon, Voscur (the support and development agency for Bristol's Voluntary, Community and Social Enterprise sector), and independently peer reviewed by Debra Allnock, University of Bedfordshire.

This needs assessment covers the geographical area, aligned with the Office of the Police and Crime Commissioner (OPCC) area, of Avon and Somerset. It includes five local authority areas: Bath and North East Somerset (B&NES); Bristol; North Somerset; South Gloucestershire; and Somerset. It builds on the SARC Health Needs Assessment, produced in 2017.

To date, there has been no sexual violence needs assessment in Avon and Somerset. There is little evidence as to the specific and varying needs of adult survivors of sexual violence in this region. Therefore the aim of this research is to ascertain the needs of survivors, and consider how adult sexual violence services in Avon and Somerset can better meet those needs.

The framework for the structure of the needs assessment is the guidance on the contents of an “effective needs assessment” in the Violence Against Women and Girls (VAWG) commissioning toolkit (Home Office, 2016, p.14).

The key findings from the needs assessment can be grouped into the following themes:

- Prevalence of sexual violence

Section 1 examines national data, in the context of local populations, demonstrating the possible numbers of men and women affected by sexual violence. These figures are higher than Police-reported sexual offences, and higher again than those accessing sexual violence services (Section 4). Within the area of Avon and Somerset, there is significant variation in populations and their local environment, which impacts on both the nature and prevalence of sexual violence that occurs.

- Need to raise awareness of available support and how to access it

Survivors most commonly first disclosed sexual violence to friends, family or their partner. (Section 2) The professionals to which survivors most commonly disclosed to were counsellors or GPs, and not through other channels. Data from the wider sector (Section 5) reiterated the need to raise awareness of services amongst the workforce.

- Need to challenge myths about rape and sexual assault

Survivors described significant difficulty in speaking about the sexual violence they had experienced; some specifying that they were worried about blame or being believed (Section

2). The stigma that exists in society about rape and sexual assault was also described as a barrier for some Black and Minority Ethnic (BME) women to get the support they need, in interviews with Imkaan (Section 3). These sentiments were echoed by public attitudes or misconceptions about sexual violence reported on in the Payne Review (2009) and in the underreporting of rape in the Her Majesty's Inspectorate of Constabulary report (2014).

Additionally, the need to encourage third party reporting of sexual violence, rather than viewing it as private business, arose from a domestic homicide review (Section 6).

- Supporting survivors to disclose and seek support

Survivors described disclosing sexual violence and first accessing services, which for the majority was a negative experience (Section 2).

- Barriers to access services

The barriers to access were significant for many survivors (Section 2). A primary consideration that this raises is the promotion and communication about available sexual violence services, so it is clear how and where to access support. Issues, such as waiting lists and awareness of available services, present survivors of sexual violence with additional barriers to accessing the support they need, once they have found the strength to begin to ask for it.

- Effectiveness of counselling

The most common support service accessed by survivors was individual counselling or psychotherapy (Section 2). It was also judged as "effective" or "very effective" by a high proportion of survivors. Counselling gave many survivors the space to process and understand the trauma that they had experienced.

- Need for greater breadth of services

The majority of survivors identified issues with the length of waiting times for services (Section 2). Sexual violence agencies also shared their waiting times for providing counselling. Consequently survivors asked a broader therapeutic offer to provide for a range of needs, and a continuum of support, that can 'hold' survivors while they wait for counselling and/or offer step-down support after completing counselling, where necessary.

- Specific needs of survivors

Groups of survivors have specific needs they want support for from sexual violence services. Collated in Section 3 are some practice solutions which can better provide for the needs of BME survivors, survivors with learning difficulties and disabilities, Lesbian, Gay, Bisexual and Trans Plus (LGBT+) survivors, men, and those with multiple/complex needs.

In two domestic homicide reviews, the learning reiterated the additional and/or unmet needs of men or survivors of sexual violence with multiple or complex needs (Section 6).

- Under-presentation in services

Data from local services showed that the numbers of survivors being supported by services is much lower than those believed to be affected by sexual violence in all areas (Section 1). Under-presentation in services is particularly marked in Somerset (Section 4). Survivors in Bristol are more likely to access services, which could be due to the difference in provision and access to services for survivors in each local authority area.

- Additional high-need populations

Prison populations, men and women engaged in street-sex work and women and girls who have experienced or are at risk of female genital mutilation (FGM) have additional and specific needs in relation to sexual violence (Section 6). There are services, other than specialist sexual violence services, that work with a cohorts that are disproportionally affected by sexual violence.

Contents

Definitions

Sexual Violence

"Sexual violence is defined as a sexual act committed against someone without that person's freely given consent" (CDC, 2018). It includes rape, sexual assault, sexual harassment, female genital mutilation, trafficking, sexual exploitation, and ritual abuse. Even if victims of sexual exploitation or 'street sex' consented, we know it is often under constrained circumstances and, as such, would not constitute 'freely given consent'.

Sexual Violence Services

Adult sexual violence services can be defined as a broad spectrum of services designed to meet the needs of survivors of sexual violence. These include, but are not limited to:

- Crisis / immediate help and information
- Individual counselling/psychotherapy
- Online email service
- Peer support
- Phone support, e.g. helpline
- Support worker
- Therapeutic groups
- Trauma-informed CBT

Age

This needs assessment focuses on young people (aged 16-25 years) and adults who have experienced sexual violence. Three-quarters of all adult service users contacted Rape Crisis Centres about sexual violence that took place at least 12 months earlier; 42% were adult survivors of child sexual abuse (Rape Crisis England and Wales, 2017). Therefore the needs assessment does include consideration of child sexual abuse in all of its forms, including exploitation, as many survivors access services or need support in relation to historic offences.

Method

This section outlines the research study undertaken between November 2017 and January 2018 to support this needs assessment.

Stage 1: Desk-based research

Desk-based research identified initial themes for the research. This included a review of relevant literature, to identify available research on the needs of survivors, and an analysis of data from the specialist sexual violence agencies that currently deliver services in Avon and Somerset.

Referral data was collected from a number of agencies to identify the extent of need across each of the local authority areas in Avon and Somerset. These included:

- The Bridge, Sexual Assault Referral Centre (SARC)
- The Green House
- Kinergy
- Safelink
- SARSAS
- The Southmead Project
- Womankind

Service delivery and case recording vary across the seven agencies that shared their data. Therefore, the information captured did also vary in some cases. Where the figures are not comparable, then they have been excluded from the total sum and this has been made clear in the text, so as not the skew the findings.

Stage 2: Exploratory research

We designed and circulated two online surveys: one for survivors of sexual violence to share their experience of disclosing and accessing support; and another for the workforce to share their experience of referring survivors of sexual violence to specialist agencies.

Workforce views and experiences of referring clients to sexual violence agencies were gathered in an online survey, which was distributed via direct contact with agencies, commissioners and Voscur's social media/e-bulletin. 50 respondents completed the survey between Wednesday 29 November and Monday 18 December 2017.

Survivors shared their experiences in an online survey open from Wednesday 29 November 2017 until Monday 8 January 2018. The online survivor surveys were publicised and email-circulated by sexual violence service providers, where they had prior permission to contact survivors to inform service improvement. A total of 30 respondents participated in the survey. This small sample size is a limited sub-set of the actual population of survivors of sexual violence. The decision to circulate the survey in this way was taken due to the ethical consideration not to directly contact survivors of sexual violence without prior permission. Unprompted contact could trigger unwanted effects of trauma. However, samples are never wholly representative – particularly in this context, where the full extent and prevalence of sexual violence is not known.

Stage 3: Workshop and Interviews

Voscur hosted a workshop event for providers and commissioners of sexual violence services to participate in the needs assessment on Thursday 11 January 2018. 33 professionals shared their knowledge and experience of both sexual violence pathways and the needs of the survivors with whom they work.

Imkaan, an independent national women's organisation dedicated to addressing violence against Black and 'Minority Ethnic' (BME) women and girls, conducted structured interviews with BME survivors on Tuesday 16 January 2018. Survivors were recruited for interviews through both sexual violence services and BME organisations in Avon and Somerset. 5 women participated in the interviews. Women were aged between 24 and 46 years, with an average age of 35 years. Women identified as black, dual heritage (black and white), African and black Caribbean. One woman was in the process of seeking asylum (submitting an appeal). During the interviews about service use, Women voluntarily shared difficult and traumatic experiences of sexual violence and exploitation. This small sample is not intended to reflect the experiences of all BME women, or men, however their experience can demonstrate the particular issues for some BME survivors in accessing and sustaining engagement with a sexual violence service.

Relevant Literature

A review of the available research that contributes to our knowledge of sexual violence and adult sexual violence services in Avon Somerset.

Demographic information

Sexual Assault Referral Centre (SARC) Health Needs Assessment (Tamlyn, 2017)
This needs assessment contains data on prevalence of sexual offences and the needs of survivors in the South West, specifically with regard to the health and support services at the SARC. The SARC health needs assessment provides an overview of the prevalence of sexual violence across Avon and Somerset, and where there is an increased incidence, for example, high population of young people or rates of unemployment.

An overview of sexual offending in England and Wales (MOJ, HO and ONS, 2013)
This bulletin provides headline statistics on the prevalence of sexual offences in England and Wales. Approximately 85,000 women and 12,000 men are raped (including assaults by penetration and attempts) in England and Wales every year. This amounts to roughly 11 rapes, of adults alone, every hour. The bulletin also provides headline data on types of offence and characteristics that increase likelihood of experiencing assault, e.g. females aged between 16-24 years.

These provide an overview of the prevalence of recorded sexual offences in Avon and Somerset, and the populations where there is an increased incidence of sexual violence.

Survivor Experience

Building Effective Responses: An Independent Review of Violence against Women, Domestic Abuse and Sexual Violence Services in Wales (Berry et al. 2014)
This report sought to involve survivors and inform the service response in Wales. Reports of sexual violence, including historic abuse, were found to be increasing and a half of services surveyed described their organisations as providing sexual violence services. Learning from this being that wider service providers need to be informed by expertise developed in specialist sexual violence services.

This report presents survivors' experiences of services in Wales. The learning about what survivors of sexual violence need from services can be applied to Avon and Somerset, where relevant.

Inclusion

Between the Lines (Thiara et al, 2015)
This report presents national research on the extent to which BME women and girls are disclosing sexual violence and accessing related services, which evidences emerging barriers to accessing support and gaps. Its recommendations for improving the service response have relevance for services in Avon and Somerset.

Building Effective Responses: An Independent Review of Violence against Women, Domestic Abuse and Sexual Violence Services in Wales (Berry et al. 2014)

In consideration of BME survivors' access to services, the report recommended interpreting services need to be made more easily accessible and interpreters need to be appropriately trained and more closely linked to specialist sexual violence services.

Access to specialised victim support services for women with disabilities who have experienced violence (Woodin and Shah, 2014)
A study of women in the UK and in three other European countries identified that women with disabilities and learning difficulties commonly experienced sexual abuse and violence, but faced a number of barriers to recognising sexual violence, reporting it and accessing support. This has implications for service delivery in Bristol with regard to this group of survivors.

Exploring the service and support needs of male, lesbian, gay, bisexual, and transgendered, black and other ethnic victims of domestic and sexual violence (Hester et al, 2012)
A national piece of research studied the particular experience of domestic and sexual violence for service users from specific minority groups, and their related service use. The report acknowledges that the findings relate to small samples of service users, but does identify trends within the research and makes associated recommendations. All service users participating in the research wanted a choice of male and female practitioners; BME women also wanted a choice of BME practitioners who might have a better contextual understanding of their experience.

These reports indicate that sexual violence affects a wide and diverse cohort of individuals, with specific and differing support needs. Gender, ethnicity, disability and sexuality affect the experience of sexual violence. As such, the needs of disabled, male, BME and LGBT and survivors may differ from heterosexual female survivors.

Sexual violence services

More than support to court (Hester and Lilley, 2017)
This research found the response for survivors of sexual violence involved a range of different services (including the SARC, rape crisis centres, Independent Sexual Violence Advisors (ISVA) and domestic violence services) for victims/survivors who had differing and complex needs. This was found to be a strength rather than a weakness as the complex and changing needs of survivors were more likely to be met by a collaborative network of specialist providers.

Hidden Depths: a detailed study of Rape Crisis data (Lovett and Kelly, 2016)
An analysis of data held by 18 Rape Crisis Centres across England and Wales found that the majority of service users were female, and the proportion of children and young people was increasing. Three quarters of service users had experienced sexual violence in childhood, while a third experienced sexual violence in adulthood. Perpetrators were most often known; most commonly family members, followed by acquaintances and intimate partners.

The importance of a network of specialist providers is relevant to sexual violence services, but it does not provide any further detail on what the benefit of a network of specialist providers is and how it can be improved.

Research from Rape Crisis data identifies headlines about the profile and experience of those accessing Sexual violence services nationally. Particularly relevant is that a high proportion of adult service users had experienced sexual violence in childhood.

Wider services

Prisoners' childhood and family backgrounds: results from the Surveying Prisoner Crime Reduction (SPCR) longitudinal cohort study of prisoners (Williams et al, 2012)
A survey of 1,435 prisoners in 2005/6 asked about experiences of abuse as a child. 29% of those surveyed stated that they had experienced abuse as a child, and of those 31% experienced sexual abuse.

Women's mapping project and evaluation of the Women's Night Centre (Henry et al, 2010)
A survey of 94 women at a Bristol night service found that 16% of women presented needing immediate help with sexual abuse or violence, while a further 15% required support for problems with sexual violence in the future. However, over half the women had more than six needs that were of immediate concern; while a further fifth of the women presented with more than 10 needs. In most cases, needs relating to sexual violence occurred alongside other needs, such as a safe place to stay, finance and debt, health and wellbeing and substance misuse. This evidenced the complexity of the issues facing those with multiple needs, which has implications for the difficulty in accessing and engaging in sexual violence services.

Corston report (Corston, 2007)
The Corston report focused on women in the criminal justice system, finding that one in three women in prison had experienced sexual abuse in their lifetime compared with just under one in ten men. This identified the female prison population as a high-need cohort for sexual violence services.

In line with findings in Wales (Berry, 2014), these reports identify other services that are likely to be working with men and women affected by sexual violence. A sexual violence needs assessment in Bristol, therefore, needs to consider wider support services.

HMIC and Cabinet Office reports

Crime-recording: making the victim count (HMIC, 2014)
A report on crime and incident recording found inaccurate practice in recording rape and other incidences of sexual violence. The inspection found 37 cases of rape were not recorded as crimes. 26% of incidents of sexual violence (including rapes) were unrecorded. Furthermore, a no-crime decision was made in 20% of cases; in 22% of these no-crime cases the victim was not informed of the decision. Due to under-recording, the prevalence of sexual violence is unknown.

The Government Response to the Stern Review: An independent review into how rape complaints are handled by public authorities in England and Wales (Cabinet Office, 2011)
This report sought to respond to the under-reporting of sexual violence, by making recommendations to improve the way allegations of rape are handled and to encourage victims to disclose their experiences.

Rape: the victim experience review (Payne, 2009)
This review sought to understand how the criminal justice system's response to rape could be improved. Two overarching themes were presented in the findings; that of societal and professional attitudes to rape victims and the inconsistency of treatment of victims.

These government reports highlight that the stigma and common myths associated with incidents of sexual violence result in underreporting. Therefore the true prevalence and extent of sexual violence is unknown.

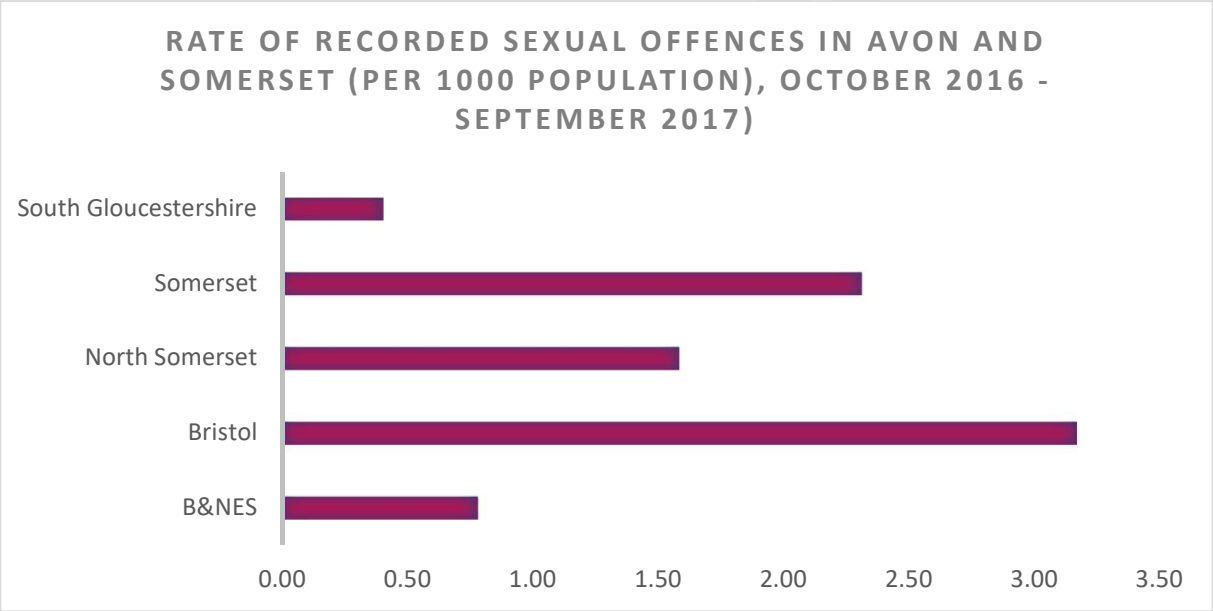
Section 1: Demographics

This section brings together available data on the prevalence of sexual violence across the populations within this needs assessment.

Sexual offences

The rate of sexual offences recorded by Avon and Somerset constabulary was 2.0 per 1000 population in 2016/2017, just below the national average of 2.1 per 1000 population, and represents a 7% increase on the rate for 2015/2016 (ONS, 2017).

Avon and Somerset Police and Crime Commissioner (PCC) data on sexual offences, from 1 October 2016 – 30 September 2017, demonstrates the spread of reported sexual offences across local authorities within the area. This shows the highest concentration of these occurring in the larger populations of Bristol and Somerset.



However, reporting of sexual violence is low. Headline data from Rape Crisis England and Wales found that only around 15% of those who experience sexual violence choose to report to the police at all (Rape Crisis England and Wales, 2017).

Information collected by rape crisis services across the South West (Cornwall, Devon, Gloucestershire and Somerset and Avon) suggests reasons for not reporting are personal to the individual survivor's experience. Survivors of serious sexual assault identify issues such as:

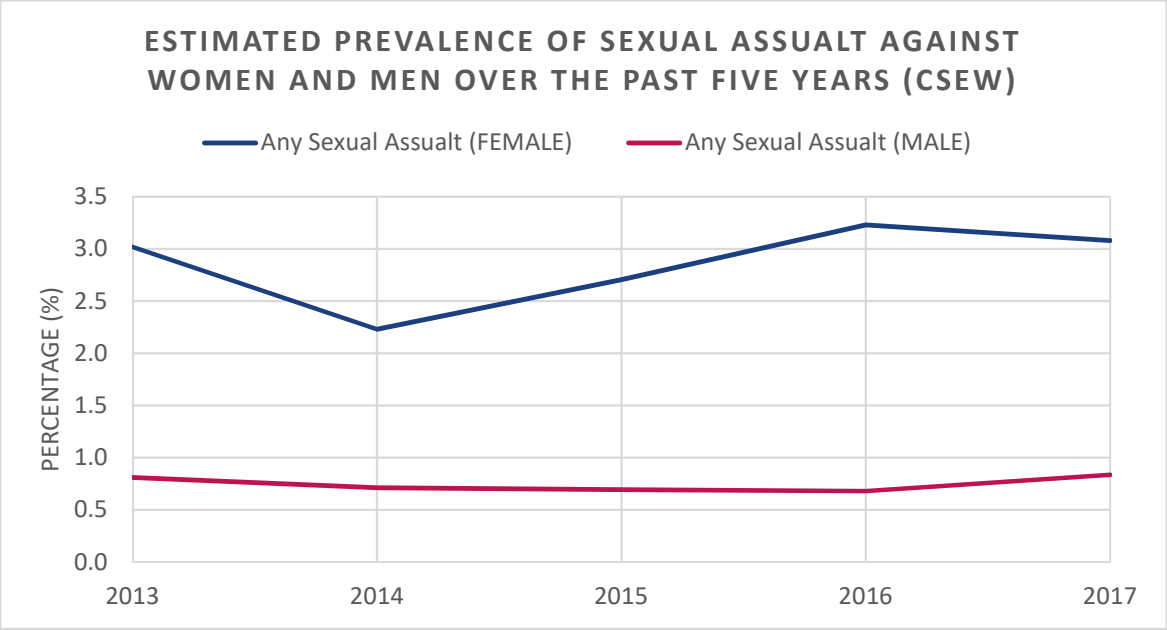
- Uncertainty about being believed;
- Embarrassment;
- Fear of being judged;
- Fear of being blamed;
- A traumatic response to the event;
- Thinking the police could not do much;
- Seeing it as a private, family matter;
- Or seeing it as too trivial to report.

The gap between reporting figures and estimated prevalence rates suggests a large hidden population of survivors of sexual violence. It can be assumed that there are also high proportions of hidden survivors in certain cohorts and areas due to localised issues. In 2014, Public Health England noted that while there were slightly higher rates of sexual violence in urban areas there were also higher rates of reporting (Weld, 2014).

This is significant to the rural areas, within B&NES, North Somerset, Somerset and South Gloucestershire, where there are likely to be larger hidden populations of survivors who are further away from the main support service hubs.

The Crime Survey for England and Wales

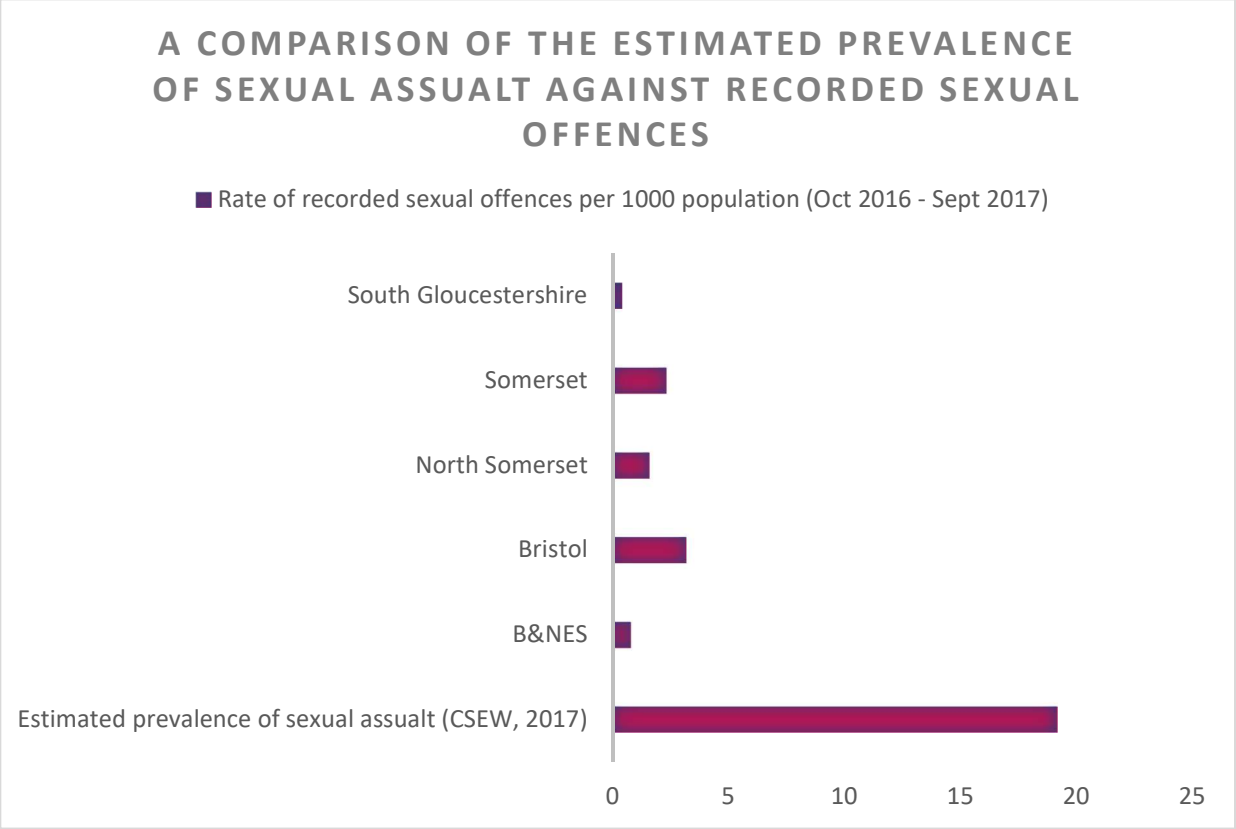
The Crime Survey for England and Wales found that 3.1% of women and 0.8% of men are estimated to have experienced a sexual assault in the past 12 months (CSEW, 2017). The average percentage estimates over the past five years are 2.9% of women and 0.7% of men; the graph below shows the small fluctuation in these figures over the period.



If we apply the most recent percentages to Avon and Somerset, 3.1% of women and 0.8% of men, using 2016 ONS population estimates, this amounts to an estimated:

- **741 men and 2948 women in B&NES;**
- **1259 men and 4728 women in Bristol;**
- **486 men and 1950 women in North Somerset;**
- **1270 men and 5053 women in Somerset;**
- **705 men and 2688 women in South Gloucestershire**; all experiencing an incidence of sexual assault in the past 12 months.

The prevalence of any sexual assault (men or women) for 2017 was estimated at 2%. The graph below compares this with the rate of sexual offences from police-recorded data.



This chart compare the 2% estimated prevalence of any sexual assault with the rate of recorded sexual offences in each area of Avon and Somerset. Different geographical areas may have a higher or lower prevalence of sexual assault; these figures are approximations based on national data applied to smaller populations. However, what it does show is that the prevalence of sexual assault is far greater than those recorded sexual offences.

Risk characteristics

Avon and Somerset covers a large and disparate area, with a mix of rural and urban populations, high deprivation and affluence, and areas of low and high ethnic diversity. The Sexual Assault Referral Centre (SARC) Health Needs Assessment for the South West has shown that the demographics of each area presents with varying risk factors (Tamlyn, 2017).

Risk factors

- Avon and Somerset has the largest proportion of 20-24 year olds in the population and the smallest older population in the South West region.
- There is a large student population.
- Within the South West, Bristol has the largest proportion of the population that are not in education, employment of training (NEET). The rate of unemployment in Bristol is above both the regional average and the higher national average.
- Bristol is the only authority in the South West to have a more ethnically diverse population than the England average.
- In contrast to the rest of the South West, Bristol and North Somerset have higher rates of mental ill health – they are the only two authorities in the South West to be above the England average.
- The proportion of those with learning disabilities who are known to the Local Authority in both Somerset and South Gloucestershire is higher than national averages.

- B&NES and Somerset have above-average rates of alcohol-specific admissions to hospital for those aged under 18, compared with a national and regional average.
- Bristol has a high estimated rate of alcohol related sexual violence, however the rest of Avon and Somerset is average.
- Bristol has a rate of opiate and cocaine usage that is two and a half times the regional average and twice the England average. B&NES is also well above the regional and national average and North Somerset is above the regional average.

Protective factors

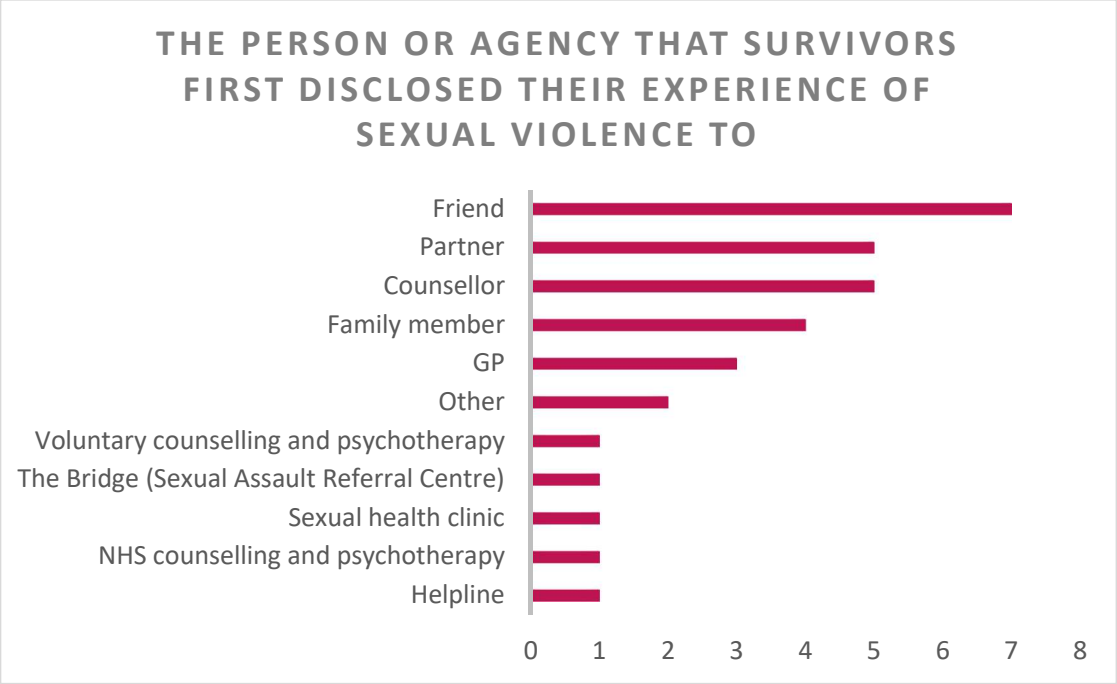
- The NEET population is relatively small in South Gloucestershire, North Somerset and B&NES. The rate of unemployment is in line with the regional average in North Somerset, Somerset and South Gloucestershire.
- Other than in Bristol, all other authorities have small BME communities.

Section 2: Survivor Experience

This section focuses on survivor experience from our survey at different stages of their journey to accessing and engaging in support from a sexual violence or other service.

Disclosure

When asked who the first person they disclosed to was, 53% (=16/30) of survivors in our survey said they first told a friend, partner or family member. Counsellor or GP were the professionals to whom survivors most often disclosed their experience, see below.



These findings, about to whom survivors first disclosed, is in line with broader research on disclosure of child sexual abuse (Allnock & Miller, 2013; Smith et al, 2015).

27 respondents described their first disclosure of sexual violence. The majority of the men and women reported a negative experience when they disclosed sexual assault or violence. Respondents described the difficulty of disclosing sexual violence, regardless of the response from the listener. It was the act of speaking about it and telling another person what had happened that was described by 89% (=24/27) of these respondents as negative.

"Traumatic. I never actually said what had happened. I couldn't find the words" Survivor

"Emotional, distressing, somewhat surreal. I was incredibly upset, but it also felt like I was disconnected and not really in control of my thoughts" Survivor

"Scary, like it would make it more real if I spoke of it" Survivor

That said, five respondents said that they either weren't believed or that their disclosure was forgotten or ignored when they first disclosed sexual violence.

Five respondents said that they did not disclose when they experienced sexual violence but a significant number of years later. This is consistent with other studies. In a study of survivors of child sexual abuse, the length of time between abuse starting and the disclosure of abuse varied widely but was an average of 16 years - almost half of the respondents did not disclose their abuse until they were aged 20 or older (Smith et al, 2015).

> *"…By the time I was 39 years old it'd become easier to talk about it. When I was younger, however, the words just wouldn't come out. It was like they were stuck in my throat and I couldn't breathe properly" Survivor*

A further four respondents in our survey expressed that they were afraid they would not be believed when they disclosed.

> *"It took me 11 years to tell anyone. I was afraid what people would think of me. She was wearing a short skirt and drunk, for example" Survivor*

BME women, interviewed by Imkaan, also expressed feeling fearful of the consequences of speaking out, not knowing who to trust and who to speak to because of the potential repercussions of not being believed and blamed for the violence.

60% (=18/30) of survivors did not report to the Police. However, there were five survivors who said they had wanted to report to the Police but did not feel confident in doing so.

Fear of reporting to the police and concern that they would not be believed was discussed by the BME women interviewed by Imkaan. For some women, this was connected to a history of mistreatment by the police, which reinforced their distrust in the police response to the violence they were subject to. Concerns were also expressed about poor responses from other statutory agencies, particularly where women previously experienced a poor response. Overall, women expressed a lack of confidence in the system's response to victims of sexual violence.

One woman spoke about being subject to police brutality and violence in her country of origin which made her fearful of any potential police intervention in the UK. She had entered the UK to escape an abusive and violent caregiver and was abandoned by the agent as soon as she entered the UK. Alone and vulnerable she subsequently became a victim of sexual violence and exploitation/trafficking:

> *"It's only now I realise the police could have helped me, that makes me mad"*

Importantly, given the difficulty that is clear in many survivors' experience of first speaking about what has happened to them, survivors experienced a positive reception at sexual violence services. The majority of survivors surveyed 'strongly agreed' that they felt believed and listened to by sexual violence services when they disclosed their experience of rape, sexual abuse or assault (70%=21/30); and respected by the staff at the service they accessed (67%=20/30).

Accessing sexual violence services

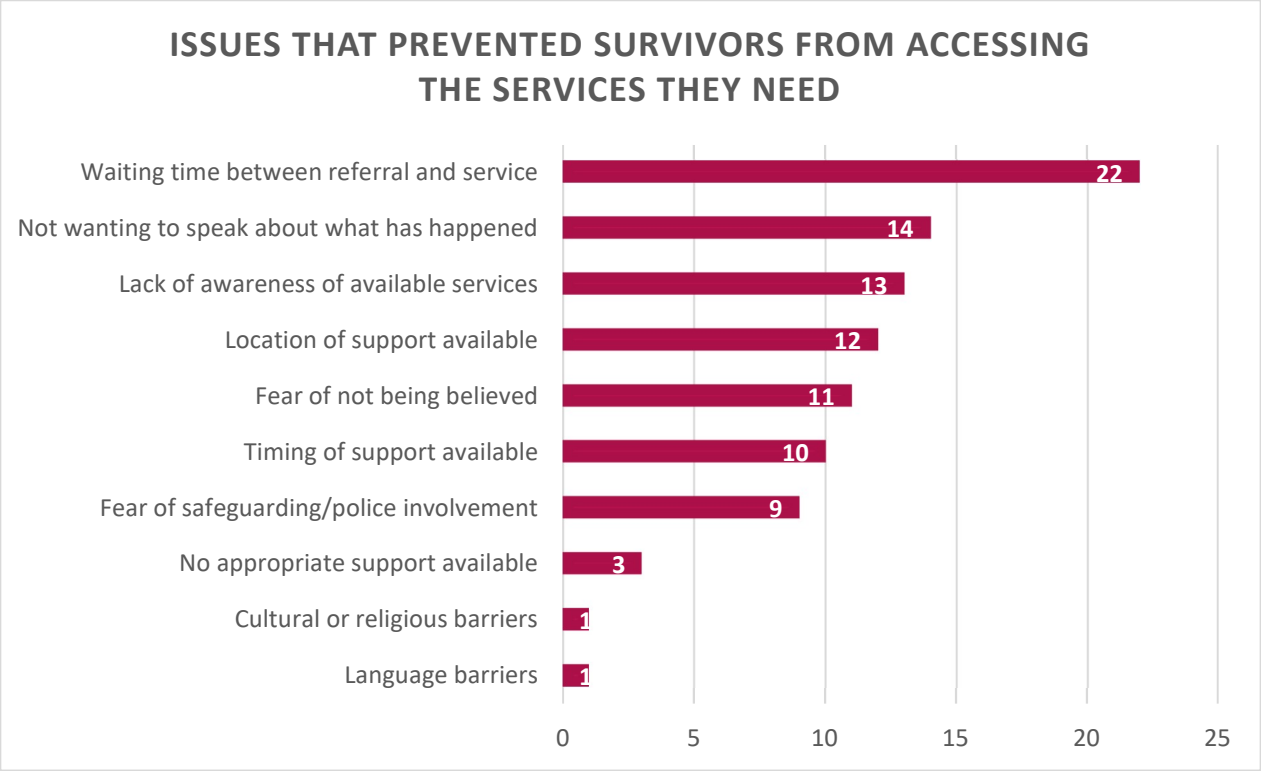
Just under half of the respondents stated they were unaware of the services and support available for rape, sexual abuse or assault when they first needed them.

Survivors found out about and accessed sexual violence services via a variety of routes, including:

- Searching online (30%=9/30))
- Someone else contacting the service on their behalf (17%=5/30))
- Posters and leaflets (13%=4/30)
- Referred by a GP, counsellor or private doctor (13%=4/30)
- Referred by the Police (10%=3/30)
- Prior knowledge of services (6%=2/30)
- Word of mouth (6%=2/30)

While 47% (=14/30) of survivors said that sexual violence services were accessible or easily accessible to them, 30% (=9/30) said they were less accessible and two respondents indicated that there were no sexual violence services accessible to them.

When asked about the issues that prevented them from accessing sexual violence services, 30 respondents identified the following 10 issues:



20 survivors used comments to share their particular experience of barriers to access services; eight of these reiterated their experience of waiting times.

"Trouble is when you find the courage to speak to someone you want to do it there and then, not in 6 weeks' time" Survivor

This issue is consistent with other findings. Waiting lists in services for children and young people who have experienced sexual abuse were found to average three months, although some services had waiting lists of up to and over a year (Allnock et al, 2015).

Some BME women interviewed by Imkaan also spoke about the difficulties they encountered in accessing one-to-one counselling because of limited provision and long waiting lists. In one situation, the woman has been referred to an organization which offers group-based trauma-based support:

"My first formal session of PTSD specific counselling (Womankind) starts tomorrow after 6-7 years of very inadequate counselling ….it was 2 weeks here or there to get me out of a really dark place or try this out for a few weeks but it never really materialises"

Four survivors described the difficulty in getting to the locations of services. Those who further detailed issues with the location and/or travel to the services they needed were based in B&NES, South Gloucestershire and Somerset.

Four survivors highlighted issues with communication or awareness of what was available to support them.

"[I] couldn't process the amount of information they were giving me" Survivor

"A few years later I found out that the majority of services only dealt with rapes that had occurred in the last 12 months" Survivor

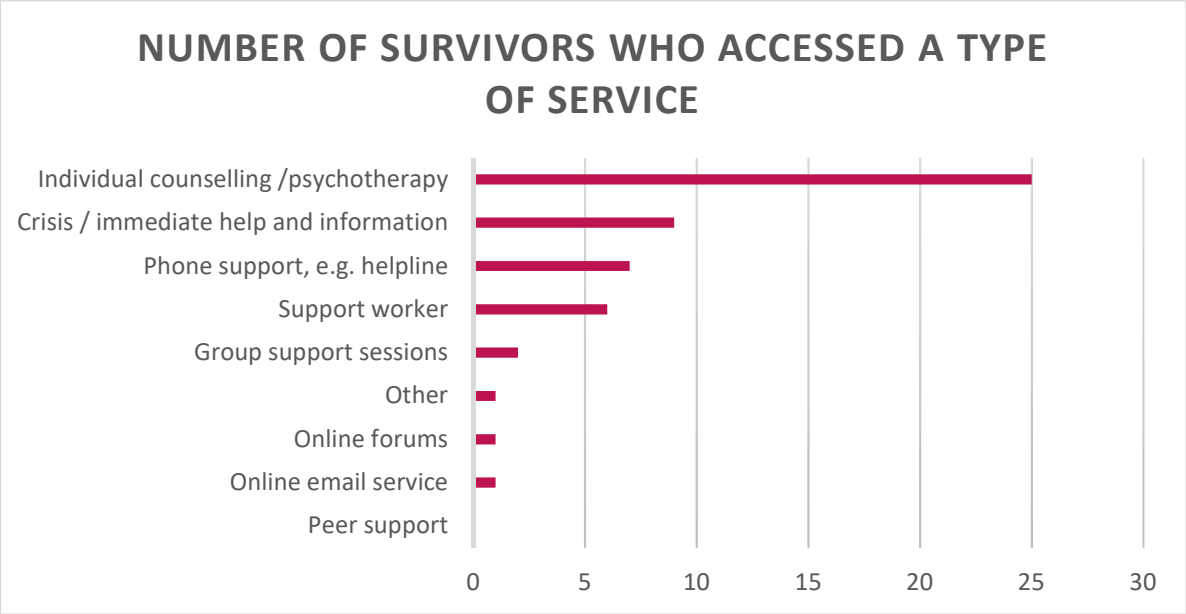
"I was totally unaware of the services available. The doctor I saw had no idea of services for sexual abuse survivors…it took me a long time to find the support" Survivor

When given the opportunity to leave a final comment, two respondents to the survey reflected on how difficult it was to get the support that they needed and how this might reflect on other survivors.

"I have felt left behind by the system…and frightened for women in less privileged positions than my own" Survivor

Service provision

The survey asked what services survivors had accessed; their experience of that service and whether they had gone onto access further support.



Individual counselling

The majority of those responding to the survey (83%=25/30 people) had accessed individual counselling or psychotherapy.

48% (=12/25) of these survivors said that individual counselling or psychotherapy had been highly effective in addressing their needs. A further 44% (=11/25) of these survivors said it had been effective.

"Gave me an understanding of trauma, the impact of the abuse…and also on my relationship with men" Survivor

"It gave me a space to speak about the darkest times in my life…the coping skills to manage my panic attacks and anxiety. I understand myself more now and know that it wasn't my fault" Survivor

"A way to…process the emotional chaos I was feeling so as to ensure minimum destruction to the rest of my life" Survivor

However, seven responses indicated a less positive experience of counselling; six of these were not sure that the counselling they received had helped in the long-term. Two survivors felt that they were not ready. Three survivors needed further support with either their mental health or moving on.

The majority of survivors (17/23) did not go on to access another service after counselling. Of those that did, two accessed further counselling. The remaining four went on to access peer support, phone support, their GP or a support worker.

It is important to note that even other services, such as phone support or support worker, often acted as a gateway to counselling. 43% (=10/23) of survivors began counselling after accessing another service.

Crisis/immediate help and information
30% (=9/30) of survivors accessed immediate help and information. The free text comments for this response indicated that some survivors understood this to be immediate sexual health or SARC response to their experience of sexual violence; others described seeking information about their options after experiencing sexual violence. The response from survivors was mixed; most were positive about the information they received. However, others found the immediate service response traumatic. One survivor "didn't feel in control of what was happening" and another described "feeling like you're being arrested and interrogated". Only two survivors went on to access another sexual violence service: individual counselling and Dialectical Behaviour Therapy (DBT).

Phone or helpline support
23% (=7/30) of survivors had accessed phone or helpline support. The reasons for accessing phone support were primarily to get emotional support or information about services.

Five of the seven survivors went onto access individual counselling after accessing phone support; the remaining two did not access further services.

Support worker
20% (=6/30) of survivors had accessed a support worker service. The positives identified were having someone to listen and receive practical support, each mentioned twice in responses from four survivors. On the other hand, two survivors felt that they had not had sufficient contact with their support worker.

Two survivors who had a support worker went on to access individual counselling or psychotherapy; four survivors did not access another sexual violence service.

Group support
Two survivors had accessed group support sessions and both reported that they had been effective in meeting their needs.

"I have made long-term friends and we are able to support each other since the group finished. Invaluable support" Survivor

In other research, peer or group support has been found to be a core component of effective support by male and female survivors (Scott et al, 2015).

One of these survivors went on to access additional phone support, but the other did not.

Email service or online forum
One survivor had used an online email service and another had accessed an online forum. Both survivors, who used an online service, used them prior to accessing individual counselling.

Additional services
Some survivors suggested additional services that would have been beneficial for them, but were not available. These were:

- An **online chat or email service**; one survivor specified that a 24 hour service would be beneficial. A further respondent asked for someone to speak to in the night which is confidential and specialist.
- **Support groups with other survivors**; one specified drop-in for survivors to go for coffee and a chat.
- A further survey respondent asked for "something while waiting for counselling where you can regularly talk and be with someone, not just over the phone".
- **Long-term support** with professionals; one specifying long-term psychotherapy.
- More **intensive or constant support**, for example, support workers in the home to assist with managing daily tasks.
- **Improved access to mental health services** and a further respondent recommended Eye Movement Desensitization and Reprocessing (EMDR) therapy as effective in treating trauma.
- Support to have **healthy sexual relationships** after experiencing sexual violence. This included help to become comfortable being touched and having sex, and also sexual therapy with a partner.

A final comment, not from the survivor survey, but from interviews with BME survivors and potentially relevance to other survivors of sexual violence, was the importance of VAWG support agencies sharing more stories of what survivors can achieve rather than presenting their experiences of violence as 'statistics' in ways 'that can dehumanise the victim'. It was felt that this would be a positive way to support survivors with recovery and move-on:

"There was no narrative about what you can achieve as a survivor and that wore down on my sense of self and owning it as a strength…. this happened to me but I can do something with it"

Section 3: Inclusion

This section focuses on groups of survivors who were highlighted in the surveys and workshop as facing barriers to access services or for whom appropriate services were not available.

Survey responses from professionals and survivors both mentioned a lack of accessible or appropriate services for BME people, LGBT+ people, male survivors and those with multiple or complex needs.

The needs of survivors with disabilities or learning difficulties are also addressed in this section. The reason for this is that those with disabilities and learning difficulties are more vulnerable to experiencing sexual violence (Woodin and Shah, 2014). The survivor survey received one example of feedback that the survey was not accessible to survivors with learning difficulties.

BME people

"The services need to realise that people of sexual assault of ethnic minority needs to be listened to in a different way" Survivor

"I'm sure that some people who are being raped and sexually assaulted do not even know that it is a crime" Professional

While the largest and most concentrated black and minority ethnic (BME) populations within the scope of this needs assessment are resident in Bristol, the issue of accessibility for BME survivors extends across the Avon and Somerset area. Where BME survivors are more isolated, cultural barriers could be compounded by other barriers to access, such as high waiting times, location or travel.

Between the Lines (Thiara et al, 2015) identified three recommendations for specialist sexual violence and other agencies that would enable the provision of an appropriate service response for BME survivors.

1. Mainstream sexual violence specialist organisations should identify and assess gaps and barriers for BME women and girls accessing their services.
2. Agencies with a responsibility for addressing sexual violence should be appropriately trained as part of on-going professional development.
3. Strengthening engagement and partnership work with local grassroots organisations would help to improve BME women and girls access to specialist advice and support.

Five BME survivors talked about, in interviews conducted by Imkaan, the elements of support that they had found valuable as part of the ongoing recovery process.

BME women interviewed by Imkaan described the stigma and shame surrounding sexual violence and a lack of understanding generally as a strong 'silencing' factor which prevented women from seeking help. Women talked about periods of their lives where they experienced overwhelming emotions of self-blame and shame, and this was reinforced by the strong stigma and misperceptions and myths which continue to exist in society.

Where women eventually accessed support from a specialist sexual violence organisation, a holistic package of support was highly valued. One woman found the support with housing, employment and other issues an essential part of the support intervention.

Women commented on the importance of consistent support and follow-up. For example, one woman spoke positively about the quality of support she receives from the specialist rape crisis centre:

> *"It didn't waver, no matter who I spoke to… I knew I could call here and get that same support… you know life deals you a lot of problems and they do come up but I knew that when I am here and with my support worker then I can tackle anything"*

Women spoke about the importance of ongoing therapeutic support both to support the immediate and longer-term impacts of violence. Some women also shared anxieties and challenges of the time-limited nature of counselling and wanted more accessible, flexible therapeutic support for a longer period to support the process of ongoing recovery.

> *"I am still in the process where I am joining the dots and I know I am getting a lot more angry about stuff now and realising things now, whereas before I wouldn't even think about it… "*

> *"I don't know what happens at the end when if you feel that you haven't dealt with everything but I'm just hoping it's a gradual process"*

Overall, women stated that access to opportunities for meeting other women (peer-support) and/or access to other social, recreational and educational activities which improved their skills/knowledge were incredibly beneficial. These opportunities help to improve women's wellbeing by reducing isolation and by having a space of safety to talk through ongoing challenges and issues. For those women who had relocated to Bristol from other areas of the country opportunities to foster friendship/community connections helped them to manage the loss of existing support networks. Women awaiting an asylum outcome stated that access to social, educational, therapeutic support helped to keep them focussed on more positive things other than their case.

Some women spoke about the importance of accessing specialist support from practitioners who could identify and understand women's individual contexts, ethno-cultural backgrounds and speak to women's specific histories and experiences of oppression. This is particularly important around how some women understand and define their experiences and how they articulate ideas of safety and protection. It was considered difficult to access BME-specific ending-VAWG support in Avon and Somerset.

> *"I have never had a black counsellor. I kind of think that might be more fruitful in terms of the discussions...For me being a black woman who was raped by a white man...had there have been a different racial dynamic I think the CPS would have been more keen to prosecute"*

In addition to these, service providers in Avon and Somerset identified the following requirements for services to meet the needs of BME survivors of sexual violence:

- **Cultural sensitivity** in all services, identifying this as an ongoing process of reflection and implementing change.

- **Learning from experience**, by capturing knowledge of how workers engage with BME survivors, e.g. use of language, and sharing this to develop capacity of the

wider workforce. This should be part of an organisation culture that continuously questions practice and uses this learning to develop services.

- **Resources for interpreting**, where necessary, to overcome language barriers and avoid the need to use partner, family or friends to interpret

- **Co-production of services** with survivors who have lived experience.

- **Community engagement**, e.g. sex education for parents, health champions in BME communities. These interventions help to bridge the gap between sexual violence services and communities who may be fearful or less knowledgeable of services. This links to the third recommendation for services from Between the Lines, that advocates for models of work "developed and delivered in partnership with BME VAWG and specialist sexual violence organisations" (Thiara et al, 2015, p.8).

People with disabilities and learning difficulties

Sexual violence was among the most frequently experienced type of violence in a study of women with disabilities in the UK and three other European countries (Woodin and Shah, 2014). This ranged from touching genitals, sexual harassment in the public to repeated rape, sometimes sustained over years.

There is a wide spectrum of disabilities and learning difficulties; a unique response is required dependent on person and need. There are particular challenges around capacity to understand sexual violence and/or make decisions about consent. In Woodin and Shah's research (2014) some women identified a lack of sex education, which later impacted their understanding of boundaries and ability to recognise sexual abuse.

Service providers identified further requirements of sexual violence services to improve accessibility for survivors:

- **Accessible communication**, developing an understanding of what information to convey and how to do so, e.g. format, language. This can make use of resources, such as the Curly Hair Project about Autistic Spectrum Disorder.

- **Audits of accessibility** for survivors, both service environments, e.g. wheelchair use, and the intervention's appropriateness.

- **Shared learning** between sexual violence agencies and disabilities and learning difficulties specialist staff, to upskill and increase capacity in both.

- **Specialist staff** with knowledge of sexual violence to effectively engage survivors with disabilities and learning difficulties.

LGBT+ people

Research centred on the service experience and needs for LGBT survivors found that the primary concern for their sample was that services would be able to deal with their sexual violence needs and LGBT issues at the same time (Hester et al, 2014). Some survivors felt their experience of sexual violence had impacted on how they saw and experienced their sexuality. In general, survivors wanted a choice of worker by gender and sexuality.

There is considerable diversity within the LGBT community, for example, transgender survivors in the research felt their needs were overlooked by most LGBT initiatives (Hester et al, 2012). There were limited specialist sexual violence services for transgender individuals. Transgender survivors in this study were more likely to access websites, chat rooms and email support.

In addition, service providers in Avon and Somerset identified further requirements of services for LGBT+ survivors:

- **Awareness raising** to understand what sexual violence is within LGBT communities.

- **Monitoring** to identify need and ensure service provision, including training for workers to ask questions and gather data. This would address a barrier, normalising the language in conversation.

- A mix of **specialist services**, e.g. LGBT Independent Sexual Violence Advisor (ISVA), and **inclusive services** that are open and accessible to all, use language, images and visibility to ensure that people feel services are for them. An example of good practice comes from the SARC (The Bridge), which has worked with LGBT Bristol to augment their service and meet all LGBT+ needs.

Men

"It still seems to be assumed that males cannot be the victims" Survivor

"A man does not disclose things like this" Professional

The focus in society is of sexual violence against women, not men, which can make it very difficult for men to disclose an experience of sexual violence. For example, research has suggested that most men who have experienced child sexual abuse only access support when they reach crisis point (Hester et al, 2012). This research identified elements of services that were important to men who had experienced sexual violence:

- Access to support services without payment
- Coordination between police and other services, by providing information about available support
- Choice of gender with worker

In addition to these, service providers in Avon and Somerset identified the following requirements for services to meet the needs of male survivors of sexual violence:

- **Use of language**, in marketing and other communications, to make it explicit that the service is inclusive.

- **Training and workforce diversity**, to reflect the client group and ensure men can be seen by men, where this is their preference.

- **Organised activities** to give male survivors the opportunity to socialise in a peer group, without sexual violence being the defining experience.

Multiple and complex needs

"I have only been given short-term support despite [being] sexually assaulted 4 times and raped twice by people I trusted … Most services are unable to provide long-term support as they have a high demand, therefore, I feel like I have not received the help I need" Survivor

"Our service users are often also facing other issues such as homelessness, problems with their scripting or needing to get on a script, drug and alcohol use, poor physical health and poor mental health" Professional

Those survivors who have multiple or complex needs require trauma treatment that works with complex lifestyles, and recognises the additional and competing needs of the individual. For example, previous research found that while 30% of women at a night shelter in Bristol had immediate or future needs regarding sexual violence, over half of the women at the shelter presented with more than six different needs (Henry et al, 2010). This has its own implications: in the majority of areas in England there is no support specifically for women affected by substance use or homelessness. Nationwide research found that in only (12.6%) 19 local authority areas in England, one of which was Bristol, do women have access to support for mental health, substance use, offending and homelessness. Elsewhere support for women facing multiple disadvantage is limited (AVA and Agenda, 2017).

Service providers in Avon and Somerset identified the following requirements for services:

- **Person-centred, holistic support** to build trust and rapport with a survivor who faces multiple issues in their life.
- **Coordination and data-sharing**, e.g. shared assessment, to reduce the need to repeat the story with multiple professionals. Better links with mental health services are particularly important for this cohort.
- **Transport and practical help,** e.g. access to GP, funds or benefits, to enable survivors to access services.
- **Flexible provision**, including the ability to work with people for a longer time, if needed.
- **Specialist workers** in services for those with complex needs.

Eye movement desensitization and reprocessing (EMDR) psychotherapy was cited as an example of trauma treatment that has been effective while complex lifestyle is ongoing.

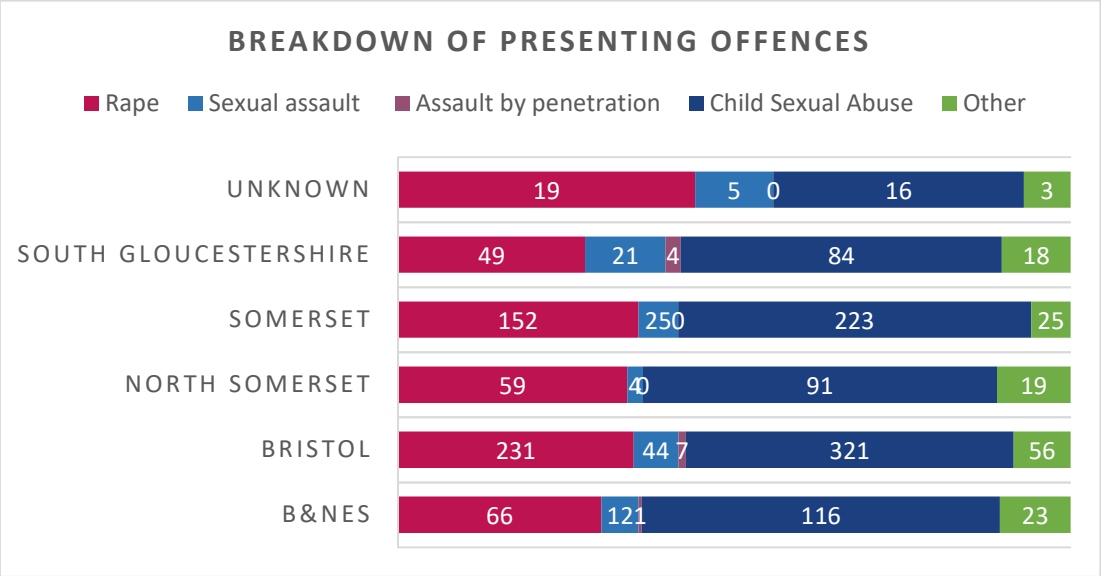
Section 4: Data and experience of local specialist services

This section considers data from local specialist services and Avon and Somerset PCC, and a picture of provision across Avon and Somerset in terms of service availability.

Referral data

Data collated from seven specialist sexual violence services in Avon and Somerset showed that 2,436 individuals accessed services as a new referral between 1 April 2016 and 31 March 2017.

Where agencies were able to provide it, a breakdown of presenting offences showed that child sexual abuse was the most common incident that individuals sought support for, closely followed by rape. This trend occurs across all local authority areas in Avon and Somerset:



The numbers of individuals accessing services for support following an assault by penetration is noticeably low, though this could be due to the unhelpful legal term, which survivors, their supporters or professionals may not use. Male survivors are an example of a particular cohort that would not fall under this category.

Overall, the trend is roughly similar across each local authority area; the highest number of survivors present with experience of child sexual abuse, followed by survivors presenting with experience/s of rape. This gives an indication of the trauma that survivors accessing support have experienced and a high level of associated need.

Six of the seven specialist sexual violence agencies who shared their data recorded the local authority area of the new referral's residence. This showed the vast majority of new referrals into specialist sexual violence services were resident in Bristol.

The chart above compares the rate of new referrals to specialist sexual violence agencies in each local authority area with the recorded rate of sexual offences. It does not include where survivors may seek other available support, e.g. community groups, health or social care providers, but it is indicative of the number of survivors of seeking support.

It could be expected that the number of survivors accessing services in Bristol would be higher: large population, better access to transport links and the availability of a number of specialist sexual violence agencies based in Bristol.

This comparison also shows a higher rate of new referrals than recorded sexual offences in B&NES, North Somerset, and South Gloucestershire. However, there are likely to be lower rates of reporting sexual assault in more rural areas, such as these and Somerset (Weld, 2014). Therefore it cannot be assumed that lower rates of recorded sexual offences mean lower incidence of sexual offences. In Somerset, the number of new referrals into services is clearly exceeded by the rate of sexual offences, and would be even more so when it is considered that rates of reporting are likely to be lower.

Furthermore, the rate of new referrals is still far lower than the rate of 19.57 per 1000 population estimated by the Crime Survey for England and Wales (Section 1). We can conclude that support is not being accessed by a high number of adults, children and young people, who have experienced sexual violence, in all areas.

We know there is significant variation in the availability and accessibility of services across the region. Service providers in Avon and Somerset gave a picture of the differences in provision across the region.

B&NES

A number of sexual violence services are offered to survivors in B&NES. However, transport is an issue for those survivors in more rural areas; venues for services must be accessible.

Service providers identified a lack of:

- Provision for men and boys with experience of sexual violence
- Provision for students with historic sexual abuse experience
- Awareness and acknowledgement of sexual violence amongst professionals and public

Bristol

There are a number of agencies delivering specialist sexual violence services in Bristol, which means there are multiple access points for survivors. However, this could be both a strength and a weakness, in terms of clarity in how to access services and there are barriers for specific groups of survivors, see Section 3: Inclusion.

Service providers identified further gaps in provision for survivors of sexual violence, as:

- Students accessing sexual violence services
- Sexual violence services for children and young people that are not high-need
- GP knowledge of how to support those referred
- Training for wider workforce, e.g. schools and health centres, in supporting those who have experienced sexual violence

North Somerset

A number of sexual violence services are offered to survivors in North Somerset. A sexual abuse needs assessment will be published in early 2018, followed by a strategy for the county. However, service providers identified a gap in service bases in North Somerset, meaning that many require survivors travel to Bristol to access the services they need.

Somerset

Across a large rural county with urban pockets, services in Somerset are often delivered from central hubs, e.g. Taunton and Bridgewater. Survivors are reliant on having transport and may face significant travel time from coming rural areas; this was a view shared by some in survey responses.

"It's also difficult not living in a big town or city where there seems to be more opportunities for support" Survivor in Somerset

"SARC was a long way from my location" Survivor in Somerset

"The amount of travel meant I couldn't access all the services I would have liked to, such as longer term counselling" Survivor in Somerset

Service providers identified a lack of awareness or acknowledgement of sexual violence prevalence, which in turn limits the available services for survivors.

In addition, BME women interviewed by Imkaan identified the importance of relational support from BME specialist staff and two women based in Somerset found there was no such provision available. One women requested that she be referred to a BME service, but there is no service in Somerset.

South Gloucestershire

A number of services are offered to survivors in South Gloucestershire. Few services are based in South Gloucestershire. A primary issue for survivors in South Gloucestershire accessing these is travel, identified by both survivors and service providers. South

Gloucestershire includes both rural and urban populations, and survivors may travel to Bristol where there is more capacity in services.

Survivor in South Gloucestershire asked for "funding for public transport"

"Sometimes the location of the places to go for help are in awkward places, especially if you don't drive!" Survivor in South Gloucestershire

Service providers identified a gap in service provision to address sexual violence and for the population of HMP Eastwood Park.

Section 5: Data and experience of the wider sector

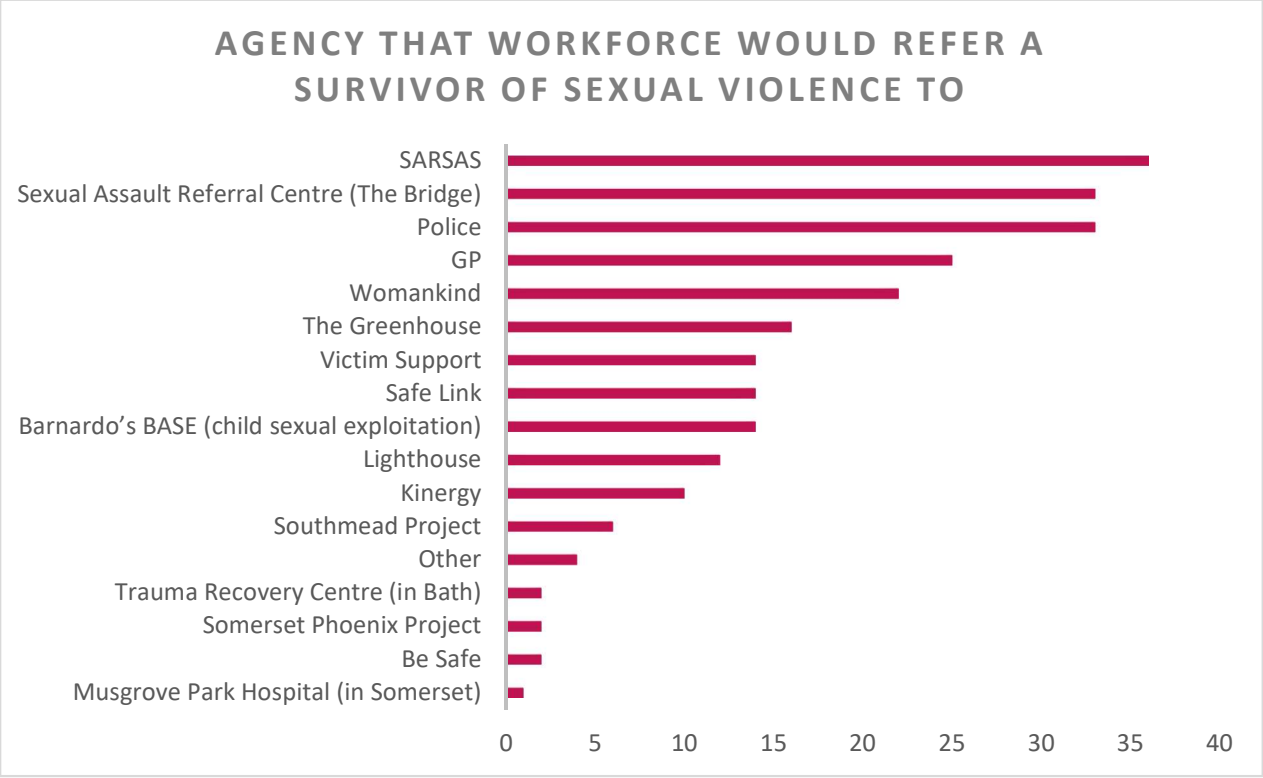
This section relates to data and experience of the wider workforce who are working with survivors of sexual violence.

Public sector services

Cross-sector respondents to our workforce survey identified the agency to which they would make a referral or suggest a survivor of sexual violence self-refer. While there is significant variation in answers, the most common referral routes were SARSAS, SARC, the Police and a GP.

The number of agencies that would refer to the Police can be compared with the survivor survey responses, where 60% of respondents did not report to the Police. The figure from our small study is much higher than other estimates of disclosure to Police, such as just 15% of survivors (Rape Crisis England and Wales, 2017). In order that survivors are adequately supported any referral to be Police should be coupled with a referral to an appropriate support organisation.

GPs were also an identified referral route for the wider sector. Similarly, in the survivor survey, the professional that survivors most commonly first disclosed to was a counsellor or GP.



Female genital mutilation (FGM)

FGM involves the total or partial removal of healthy female genitalia and is classified as a form of child abuse and violence against women and girls in the UK. Forward (Foundation for Women's Health Research and Development) work with Refugee Women of Bristol to deliver the Bristol Model, a response to tackling FGM in Bristol. An evaluation of the impact and lessons learnt from the eight year programme found that attitudes are shifting to FGM in

the city, but that there were recommendations to continue the work (Forward, 2017). These are:

- Police, social services, other authorities and particularly border control officers need to be educated about FGM issues, and to build trust among affected communities. Communities feel under threat and discriminated against, particularly with concerns that if they talk about or report FGM publicly, or even attempt to go on holiday, their families will come under suspicion or prosecution.
- Further efforts are needed to integrate migrant communities with the UK communities, to tackle their isolation but also to improve their life chances, and relieve cross community tension and suspicion. This will create an atmosphere where communities are able to pursue their traditions, but within the law and social norms of the wider community.
- Despite the good work done and achievements made, work with directly affected communities needs to continue. In particular, programmes were needed to educate and influence newly arrived migrants, and programmes were required in people's countries of origin to tackle the root ideas and traditions behind FGM.
- Older community members should be actively involved, since they are most often those with traditional views and have strong influence in their communities.
- Projects should work closely with men and boys, to educate them about FGM, violence against women and girls and the law. This is particularly important because of the strong influence and authority of fathers and husbands on women in their communities.
- Other key 'gateways' for influencing and educating communities were thought to be religious leaders, schools and among women who come from FGM practicing communities.
- Services, conversations and safe spaces should be provided for women to discuss FGM and violence against women and girls intimately and in private. Not all influencing should be loud and aggressive.

Prison services

Research has shown that the prison population in general has experienced a higher rate of sexual abuse than the general population (William et al, 2012).

The Corston Report calls for more consideration of the female prison population as a high-need cohort of women (2007). Of particular relevance to this needs assessment is the case study of 50 women who self-harmed in prisons; 38 reported that they had experienced abuse or rape in their lives. 18 women had been abused as a child.

While female prisoners were more likely to report experiencing sexual abuse than male prisoners, a survey of nearly 1500 prisoners additionally found 7% of men experienced sexual abuse as a child (William et al, 2012). Overall, approximately 9% of those surveyed in the prison population had experienced sexual abuse as a child.

The Avon and Somerset area includes three prison populations, which are:

- HMP Bristol, a local category B prison for adult males and some young offenders, from local Courts;
- HMP Ashfield, a category C prison for adult males serving sentences for sexual offences, and:
- HMP Eastwood Park, a local closed prison for adult females.

Street sex work

Prostitution exposes women to risk of rape and sexual assault; physical violence; trafficking; and sexual harassment.

A Bristol-based organisation working with women involved in street sex work provides immediate support to any women who reports sexual violence. Between 1st April 2016 and 21st March 2017, 25 reports of sexual violence were received by 18 women. The incidents were often very serious sexual assaults, for example, there were 11 reports of rape, 5 reports of gang rape and 2 reports of drug rape. In addition, some women reported multiple assaults. Four women reported two separate assaults in the period, and one women reported three separate assaults in the period. In the same period, there were 21 Ugly Mug reports, anonymous reports of incidents from sex workers about dangerous individuals. It is clear that, for street sex workers, the incidence of sexual violence is high.

This reporting is unlikely to represent the full incidence. There will be many more women engaged in street sex work who experience sexual violence. Often the woman will be homeless, so the immediate support would involve reporting to the police, attending the SARC, attending an appointment with the local authority to secure emergency accommodation and sometimes also arranging prescribed medication.

Section 6: Learning from Domestic Homicide Reviews and Her Majesty's Inspectorate of Constabulary reports

6.1 Domestic Homicide Reviews (DHRs)

Recent domestic homicide reviews have presented learning that is relevant to sexual violence services in Avon and Somerset:

The report into the death of Michael, in South Gloucestershire, highlighted the need for available services for men, including men engaged in sex work, who are at risk of exploitation or abuse from their partners (Warren, 2016). This highlights the need to promote available services for male victims of rape and sexual assault.

Learning from DHRs in Somerset suggested that agencies should work collaboratively to understand the multiple issues faced by those experiencing domestic and sexual abuse (Harris, 2017). In line with previous findings about survivors with multiple and complex needs, the response must be coordinated to take into account the multiple issues that impact on them.

The report into the death of Holly, in Bristol, found that her friends had been told that her partner was violent and raped her (Warren, 2015). The case underlined the importance of raising awareness of what and how to report any third-party concerns regarding domestic and sexual abuse, in all communities, particularly those less able to access services.

6.3 Her Majesty's Inspectorate of Constabulary (HMIC) reports on Rape Attrition

The Home Office rape victim experience review found overarching issues in the societal and professional attitudes to rape (Payne, 2009). It is known that these beliefs, and misconceptions, about rape and sexual violence influences rates of reporting and conviction. An HMIC report found 26% of sexually violent incidents (including rape) reported to the Police were not recorded (2014). The rate of police-recorded sexual offences is therefore unlikely to represent the full incidence. The inspection additionally found 37 cases of rape that were not recorded as crimes, making clear that further improvement is needed in the response to survivors that report an offence of rape and sexual assault.

Recommendations

- Sexual violence services need to raise awareness of available support and how to access it amongst both public, as survivors are most likely to disclose to family, friends or partners, and the wider workforce, e.g. GPs.

  This should occur across Avon and Somerset, as the numbers of survivors being supported by services is much lower than those believed to be affected by sexual violence.

- All providers, sexual violence services and others, must openly challenge myths and commonly held beliefs about rape and sexual assault, including consent, blame and making clear that a survivor would be believed.

  Some of this work should be targeted to BME communities where a lack of understanding and/or stigma can exist surrounding sexual violence.

- Wider workforce should make the process of disclosing sexual violence and accessing services as easy as possible, recognising the strength that it has taken to verbalise their experience, and ensure that survivors are listened to and respected when they disclose sexual violence and seek support.

- Sexual violence services to continue to provide counselling, where appropriate, to help survivors process the trauma they have experienced.

- Sexual violence services to also provide a broader therapeutic offer to provide for a range of needs, and a continuum of support, that can 'hold' survivors while they wait for counselling and/or offer step-down support after completing counselling, where necessary.

  This would also help to meet the needs of those who are not ready or willing to engage in counselling. In particular, holistic support and flexible provision would benefit survivors with multiple and/or complex needs.

- Sexual violence services to provide opportunities for peer support to meet with other survivors who understand or share their experience.

- Sexual violence services to use accessible and inclusive language and communications, and to be explicit about their accessibility and service provision, for example, where they offer support for male survivors of sexual violence.

- Sexual violence services to offer a choice over the gender and ethnicity of their practitioner, where survivors feel that this is relevant to their experience of sexual violence and have a preference.

- Sexual violence services to develop staff specialisms in working with survivors with learning difficulties and disabilities and with survivors with multiple and/or complex needs.

- Sexual violence services to provide LGBT-specific support to survivors, recognising the LGBT issues and their impact on an experience of sexual violence.

- Sexual violence services to provide BME-specific support to survivors, recognising context and ethno-cultural backgrounds, through diverse and representative staff, interpreting services and/or work with BME and community organisations.

- Wider workforce to be informed by expertise developed in specialist sexual violence services. This is in line with recommendations in other areas (Berry et al, 2014).

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Service Outcomes

Section 1 – Summary of measured outcomes

Outcome	Method of measurement	Frequency
An operational protocol will be developed and kept under review reflecting the agreed partnership working with wider agencies & SARC	The protocol will be shared with the Commissioner	Annually
Measuring the impact of the service	Report detailing the intervention used and the outcomes (eg. CORE or 'Cope & Recover Framework') for all clients accessing the service will be shared with the Commissioner.	Quarterly
Measuring the impact of the service	At 12 months of service operation there is a requirement for the provider to complete a full independent evaluation which will include service user experience feedback to inform continuous improvement of service.	1 year
Activity monitoring	A single report detailing activity described in section 2 will be sent to the Commissioners	Quarterly
Timeliness of first assessment	90% of individual assessed funded under this contract should receive their first assessment within 20 working days of the referral being made	Quarterly
Timeliness of first treatment	Baseline data detailing referral to treatment time for each individual to inform future commissioning	Quarterly
Supervision/ Peer support	Activity report that provides evidence of the following : CPD Supervision Staffing levels	Quarterly

Case studies	Provide case studies detailing case examples of the individuals presenting to the service	Quarterly

Section 2 - Activity requirements

Baseline activity should be broken down as follows by activity to be broken down by age, sex and organization supporting the individual for each of the below elements.

Counselling Services	**Number of clients & percentage of the caseload for whom this is completed**
Route of Referral	
Group work and Frequency	
Assessments	
Numbers referred into service	
Face to Face Counselling: No of People No of Sessions	
Clinical Supervision	
Care Plans in place	
All sessions completed	
No. declined	
No. exit prior to completion	
Capture as to why exit	
Nature of assault	
Demographics: Age Gender Ethnicity Area of residence (first 4 digits of postcode or local authority area)	
Number of onward safeguarding referrals	