Sexual Violence Needs Assessment for Avon and Somerset

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Above all, we are immensely grateful to those survivors who contributed their voice and experience to the research and for their comments on an earlier version of the needs assessment.

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Introduction and key findings

The Bristol Sexual Violence Support Consortium has produced a sexual violence needs assessment for Avon and Somerset. It has been produced Voscur, and independently peer-reviewed by a Senior Research Fellow at University of Bedfordshire.

This needs assessment covers the geographical area of Avon and Somerset, aligned with the Avon and Somerset Police Force area. It includes five clinical commissioning groups (CCG) and 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, commissioned by NHS England and 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 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, (Section 3). These sentiments were echoed by public attitudes or misconceptions about sexual violence reported 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 for a broader therapeutic offer to meet 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 would like to be addressed by 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.

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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 or email service
- Peer support
- Phone support, e.g. helpline
- Support worker
- Therapeutic groups

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 includes consideration of child sexual abuse, 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. It 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

Corston+10: The Corston Report 10 Years On, (Women in Prison, 2017)

This traffic light report looks at the progress of Baroness Corston's recommendations from 10 years prior. There is some progress in acknowledging the gender-specific pathway 8, the special needs of women who have experienced rape and sexual abuse, and pathway 9, support for women who have been involved in prostitution. However, the report states that this is lacking in practice, due to limited funding and resources to support high demand.

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 report remains the most comprehensive report on female offenders and prevalence of sexual violence. It identified the female prison population as a high-need cohort for support.

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.

While some of reports are between four and nearly ten years old, they indicate the stigma, common myths and misconceptions to which survivors of sexual violence have been subjected to. This is particularly relevant given that often survivors report sexual violence more than two years after the incident (Lovett and Kelly, 2016). As a result, sexual violence is often underreported and the true prevalence and extent of sexual violence is unknown.

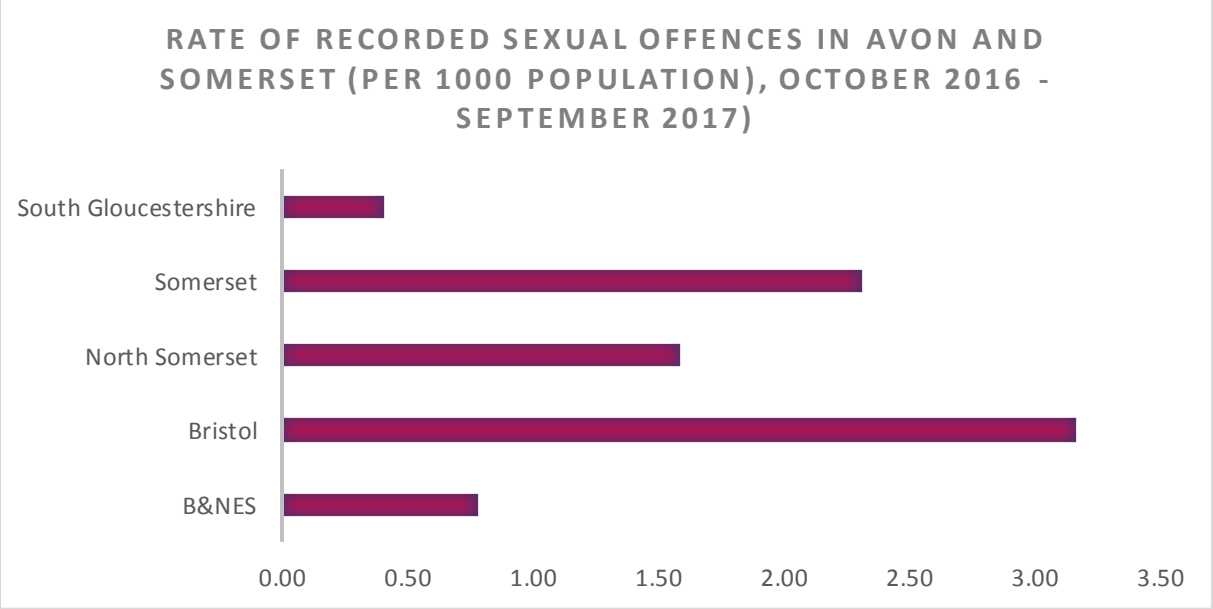
Section 1: Demographics

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 Constabulary 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;

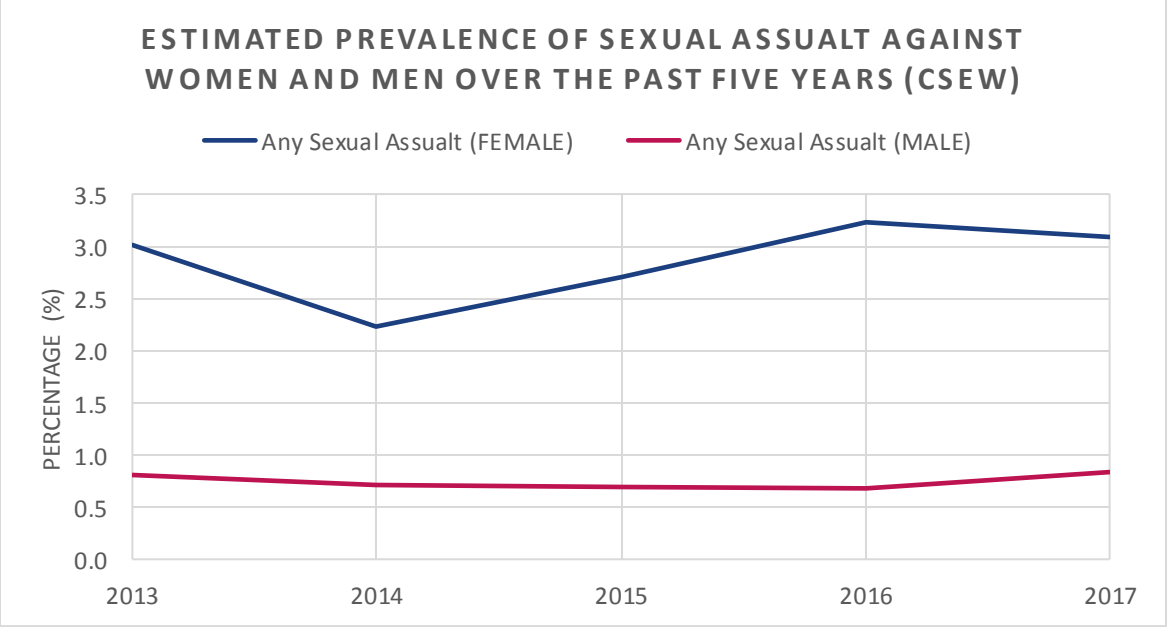
- A traumatic response to the event;
- Thinking the police could not do much;
- Seeing it as a private, family matter;
- Or seeing it as too trivial to report.

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

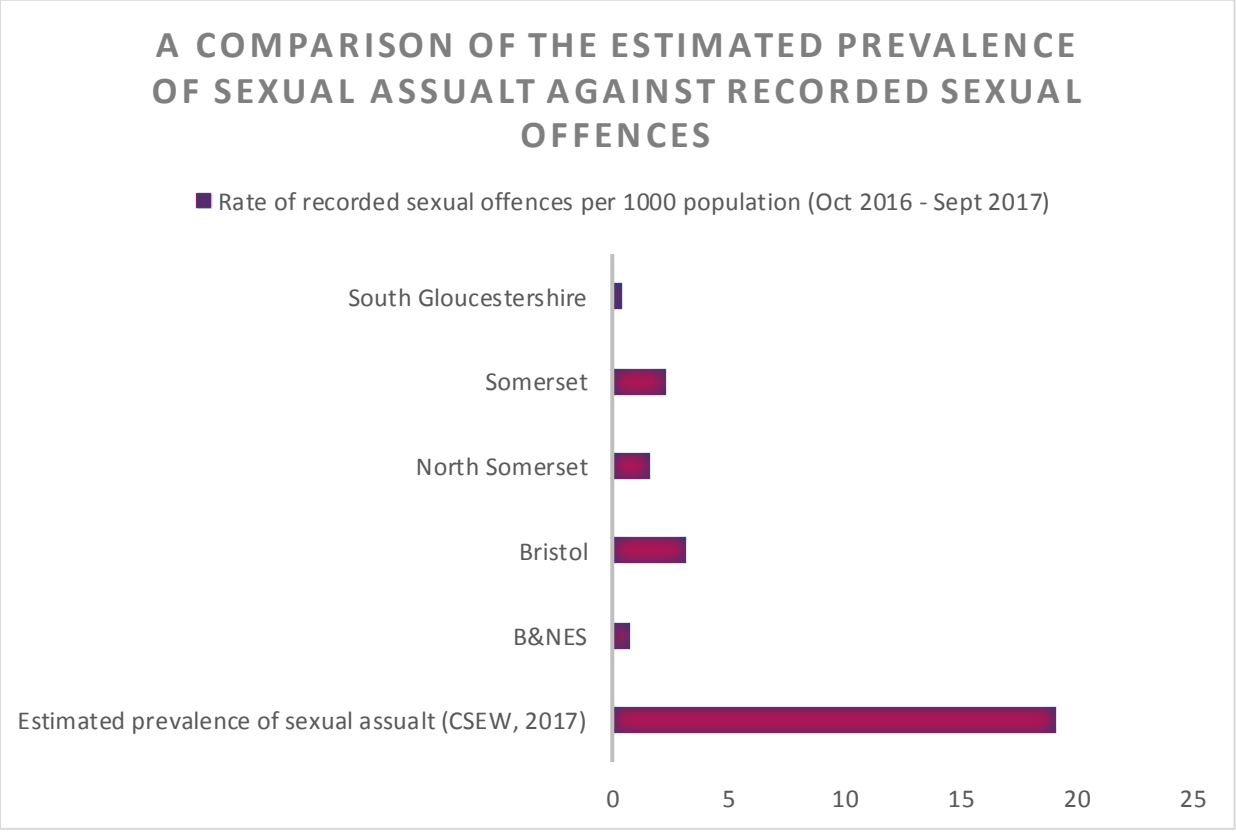
The Crime Survey for England and Wales found that 3.1% of women and 0.8% of men are estimated to have experienced a sexual assault in the past 12 months (CSEW, 2017). The average percentage estimates over the past five years are 2.9% of women and 0.7% of men; the graph below shows the small fluctuation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

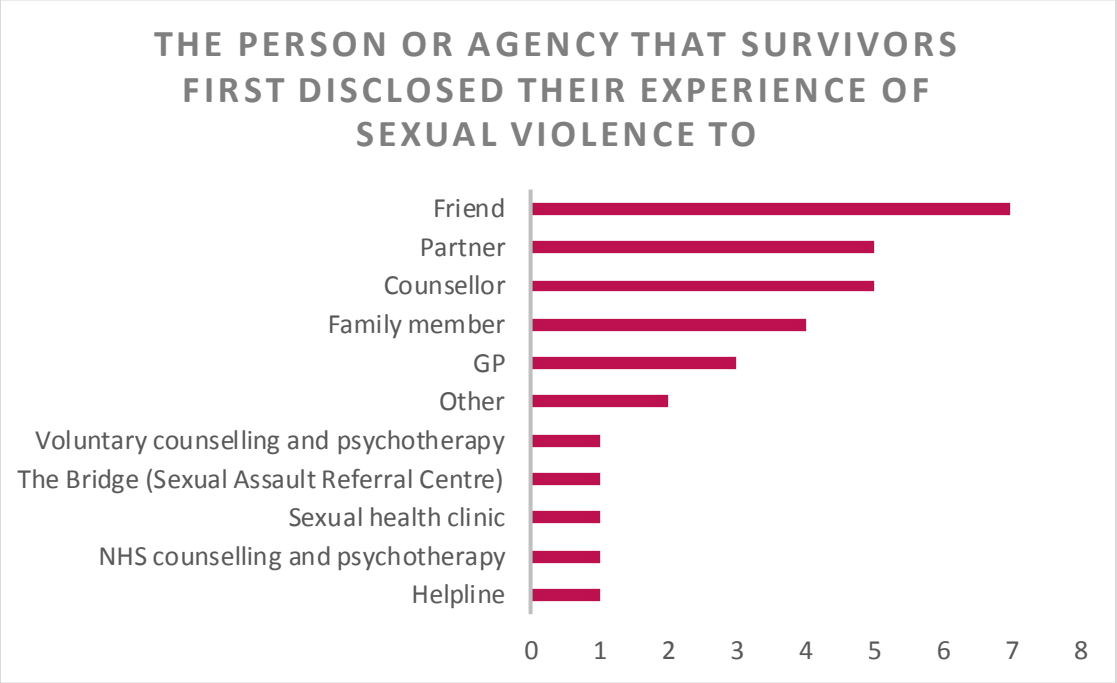
- The NEET population is relatively small in South Gloucestershire, North Somerset and B&NES. The rate of unemployment is in line with the regional average in North Somerset, Somerset and South Gloucestershire.
- Other than in Bristol, all other authorities have small BME communities.

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% 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% 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% 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%); and respected by the staff at the service they accessed (67%).

Accessing sexual violence services

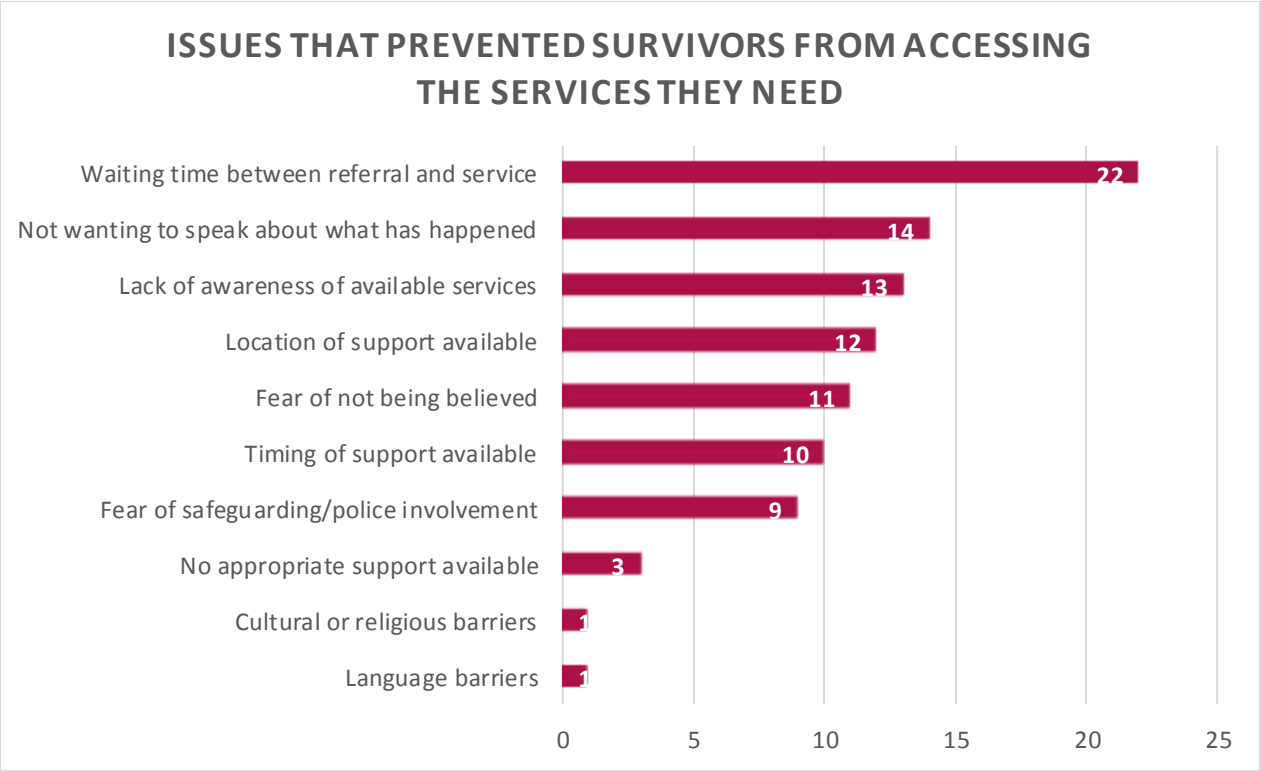
Just under half of the respondents stated they were unaware of the services and support available for rape, sexual abuse or assault when they first needed them.

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

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

While 47% of survivors said that sexual violence services were accessible or easily accessible to them, 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

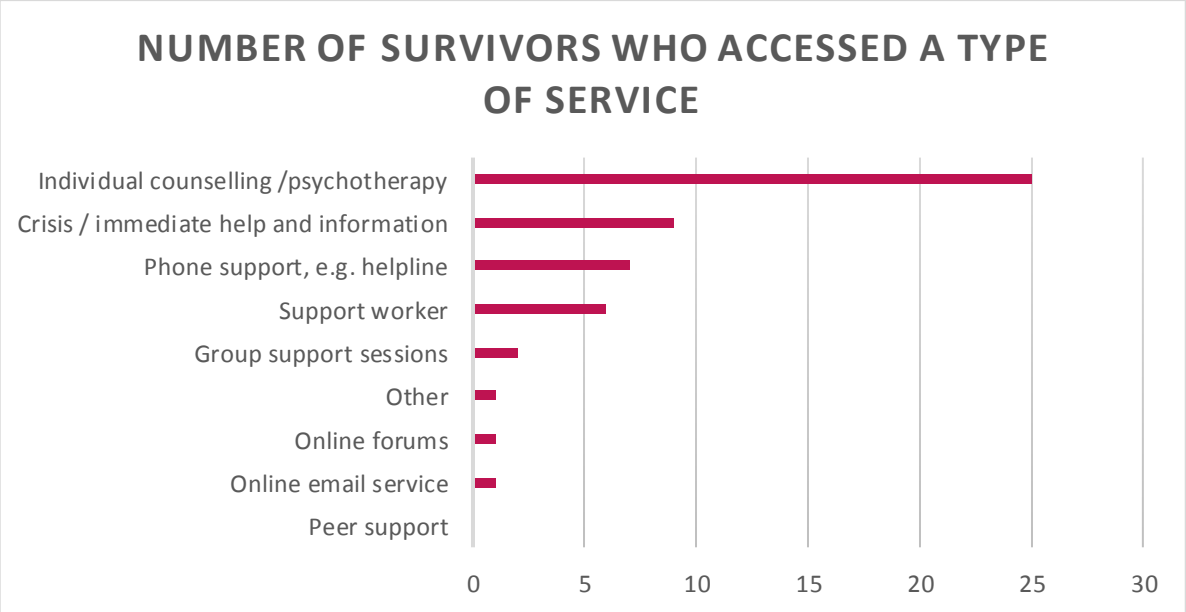
"I was totally unaware of the services available. The doctor I saw had no idea of services for sexual abuse survivors…it took me a long time to find the support." Survivor

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%) had accessed individual counselling or psychotherapy.

48% of these survivors said that individual counselling or psychotherapy had been highly effective in addressing their needs. A further 44% 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 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% of survivors began counselling after accessing another service.

Crisis/immediate help and information

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% 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% 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 survivors

"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."*

However, service providers noted that professionals being from the same cultural background can act as a significant barrier for some BME survivors, due to fear of this being disclosed to family members. This is particularly the case in communities where honour-based violence occurs.

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).

Survivors 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+ survivors

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.

Male survivors

"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

Lime Culture CIC have recently produced quality standards for services supporting male survivors of sexual violence (2018). These provide a framework and standards to improve the provision of services to male survivors and recognise their gender-based needs, across leadership and governance; access and engagement; service delivery and outcomes and evaluation. Ten organisations will be trialling a programme of accreditation, monitoring and support against the quality standards in 2018/19. The aim of these quality standards is assure male survivors that their individual needs will be understood when accessing support from a service provider.

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.

Survivors with 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.

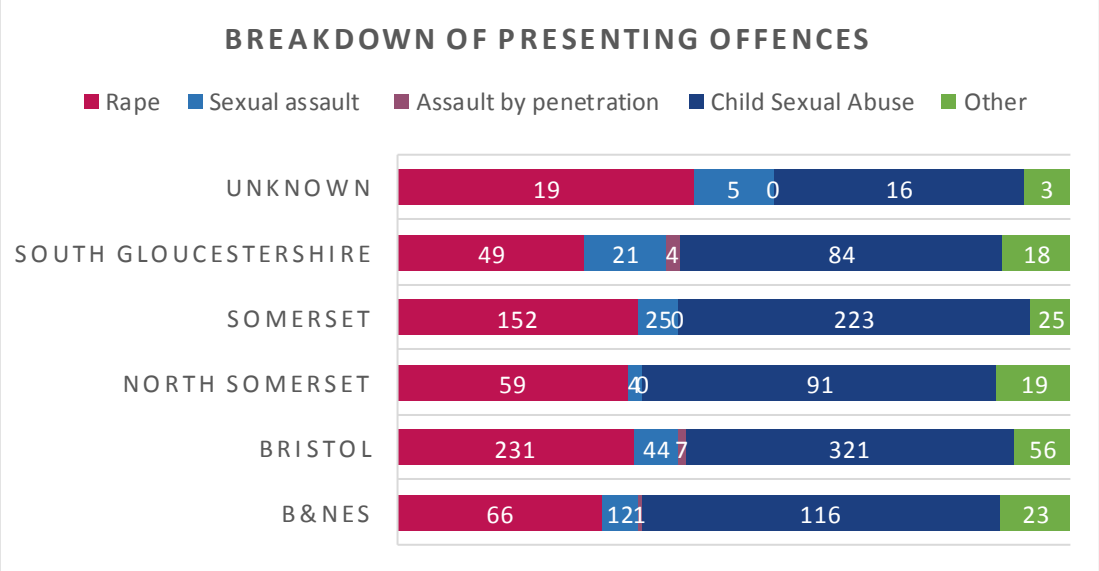
Section 4: Data and experience of local specialist services

This section considers data from local specialist services and Avon and Somerset Constabulary, 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.

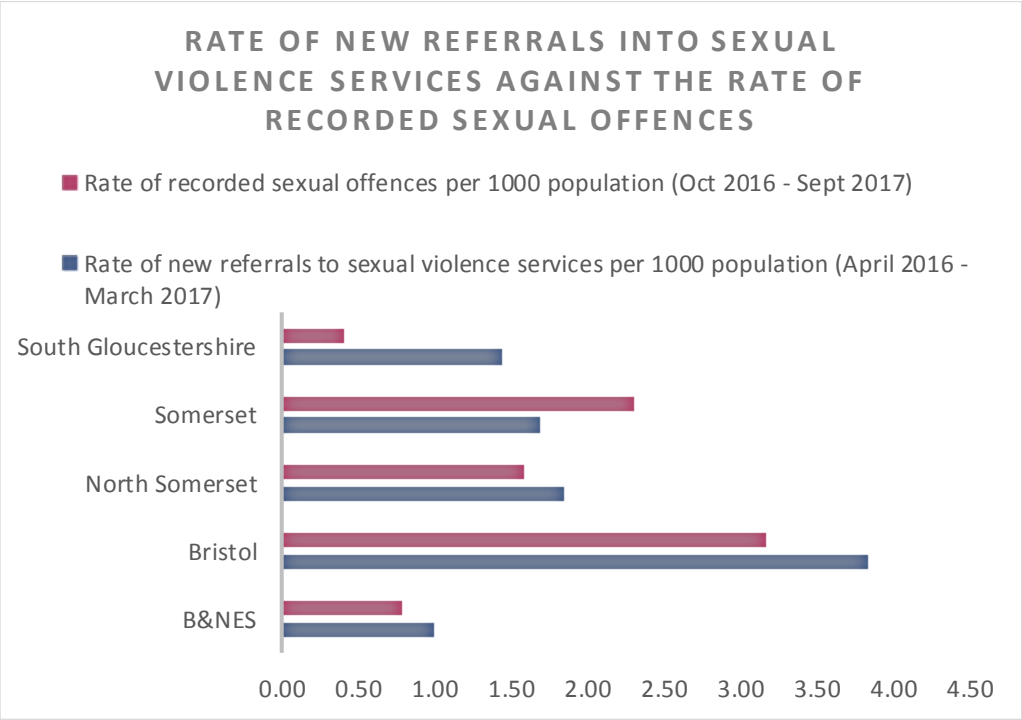
Where agencies were able to provide it, a breakdown of presenting offences showed that child sexual abuse was the most common incident that individuals sought support for, closely followed by rape. This trend occurs across all local authority areas in Avon and Somerset:



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

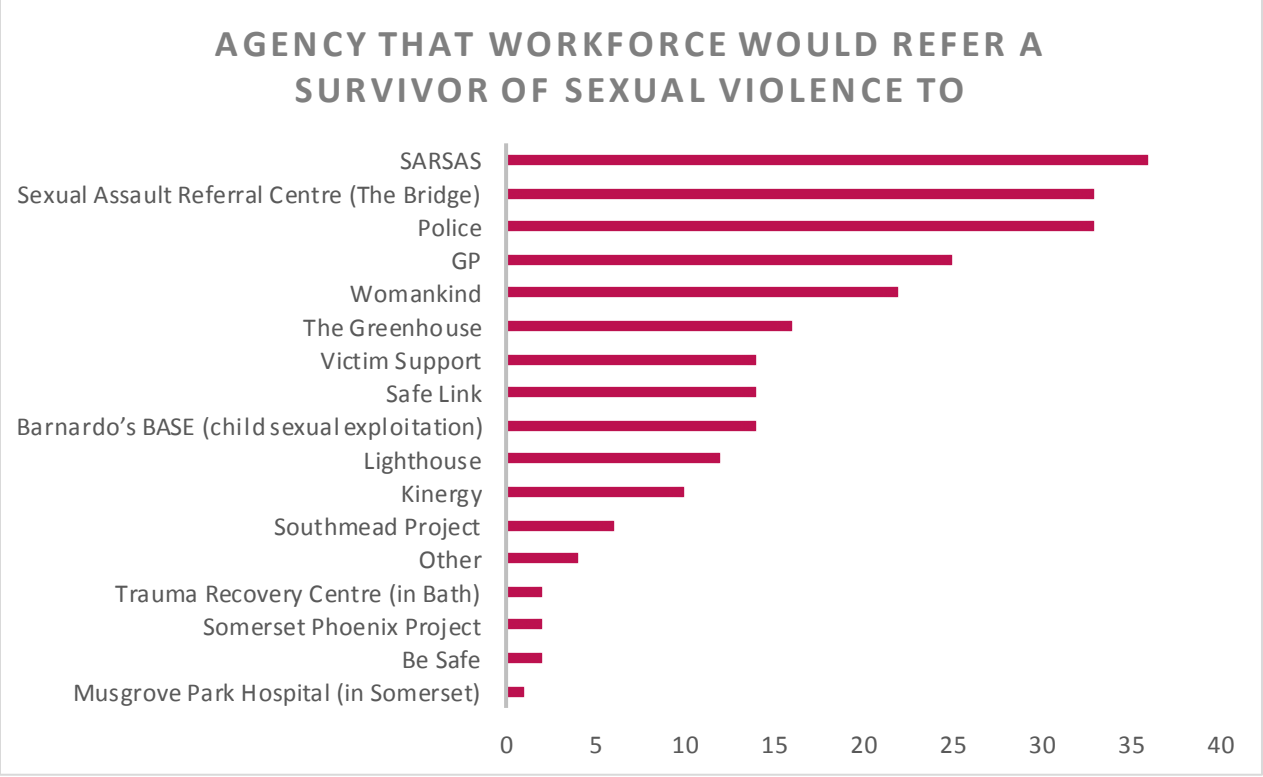
This section relates to data and experience of the wider workforce who are working with survivors of sexual violence.

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, most are specialist sexual violence or victim services. It's possible this variation results from professionals referring to an agency that is most relevant to the survivor, e.g. by presenting needs, geography or age.

A high number of these respondents would refer to the Police, compared with the survivor survey 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 additional pathways that recognise where women have been a victim of rape, sexual abuse or prostitution have been acknowledged, the provision of support is limited due to funding and lack of resources (Women in Prison, 2017). In some areas, sexual violence support is only available in community rehabilitation centres (CRCs). This means that women can only access support in the final 12 weeks of their sentence.

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

Pathway and other support services are often commissioned and delivered in establishment groupings. Local establishments, beyond Avon and Somerset, include:

- HMP Erlestoke (Wiltshire), a category C prison for adult males, and;
- HMP Leyhill (Gloucestershire), a category D prison for adult males, approximately 60% of whom have committed sexual offences (as at September 2016).

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

1. 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.

    a. 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.

2. 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.

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

3. 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.

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

5. 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.

    a. 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.

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

7. 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.

8. 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.

9. 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.

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

11. 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.

12. 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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