



SUPPORTING A PROFESSIONAL
RESPONSE TO SEXUAL VIOLENCE

Needs Assessment for Sexual Violence and Abuse Survivors in Nottinghamshire

LimeCulture Community Interest Company

October 2019

Commissioned by the Police and Crime Commissioner for Nottinghamshire and
NHS England/Improvement - Midlands

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We would also like to thank analysts from the Nottingham City County, Nottinghamshire County Council and Nottinghamshire Office of Police and Crime Commissioner, who supported us to extract and analyse data for the purpose of this report. We would also like to thank the services who were able to provide data to assist this needs assessment.

Above all, we would like to thank the victims/survivors who were willing to tell us about their experiences of accessing support following their experiences of sexual violence and abuse. As part of this work, our team spoke to more than 50 individual victims/survivors of sexual violence and abuse, including children and their parents/carers. Each one of them has had traumatic experiences that have shaped their lives and individual circumstances. The Project Team would like to thank every single one of them for sharing with us their views and suggestions.

In addition, over 50 individual victims/survivors of sexual violence and abuse responded to our online survey and provided us with further important information about what they want and need in terms of support. The willingness of each of them to share details about their support needs has enabled us to ensure that the voice of victims/survivors is central to this important piece of work.

Glossary

A&E	Accident and Emergency
BACP	British Association for Counselling and Psychotherapy
BAME	Black, Asian and Minority Ethnic Group
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
ChISVA	Children's Independent Sexual Violence Advisor
CPS	Crown Prosecution Service
CSA	Child Sexual Abuse
CSE	Child Sexual Exploitation
CSEW	Crime Survey for England and Wales
DA	Domestic Abuse
FFLM	Faculty of Forensic and Legal Medicine
FME	Forensic Medical Examiner/Examination or Forensic Physician
FME	Forensic Medical Examiner
FNE	Forensic Nurse Examiner
GP	General Practitioner
GUM	Genitourinary Medicine
IAPT	Improved Access to Psychological Therapies
ISVA	Independent Sexual Violence Advisor
LA	Local Authority
LGBT	Lesbian, Gay, Bisexual and Transgender
LSCB	Local Safeguarding Children Board
MYE	Mid Year Estimates
NHS	National Health Service
NHSE	National Health Service England
NUH	Nottingham University Hospitals NHS Trust
ONS	Office for National Statistics
PCC	Office of the Police and Crime Commissioner
PCC	Police and Crime Commissioner
PEPSE	Post-Exposure Prophylaxis Following Sexual Exposure
PHE	Public Health England
QMC	Queen's Medical Centre – part of Nottingham University Hospitals NHS Trust
RCPCH	Royal College of Paediatrics and Child Health
RMG	HMIC Rape Monitoring Group
SARC	Sexual Assault Referral Centre
SARCIP	Sexual Assault Referral Centre Indicators of Performance
SAAS	Sexual Abuse & Assault Strategy
SAS	Safety and Support Assessment
STO	Specially Trained Officer
SVLO	Sexual Violence Liaison Officer

Executive Summary

In late July 2019, the Police and Crime Commissioner for Nottinghamshire (PCC) and NHS England & NHS Improvement Midlands commissioned LimeCulture Community Interest Company (CIC) to undertake a Mental, Physical and Sexual Health, Social and Economic Needs Assessment for Sexual Violence and Abuse Survivors in Nottinghamshire.

The purpose of the needs assessment is to inform the commissioning of services by identifying the needs of sexual violence and abuse survivors, the support services required and the likely demand in Nottingham and Nottinghamshire.

The objectives of the needs assessment (as set out in the specification document) are to:

- a) Identify the prevalence, need and demand relating to sexual violence and abuse,
- b) Identify the presenting needs of survivors who are accessing specialist and generic voluntary and public sector support services, specifically capturing data about multiple and complex needs where this is available,
- c) Work with a wide range of community groups and public and voluntary sector providers to gather views from survivors of different types of sexual violence and abuse about their needs,
- d) Facilitate a focus group/focus groups with a range of professionals from NHS services and specialist voluntary sector sexual violence services to determine health needs and how they are best met,
- e) Facilitate (a) discussion/s with practitioners and stakeholders from public and voluntary sector services about survivors' health, wellbeing, social and economic needs and how best to meet them,
- f) Consider and identify needs across all elements of survivors' pathway, including but not limited to:
 - crisis support,
 - health and well being needs specifically including sexual health and mental health needs including counselling and therapeutic services,
 - economic and social needs,
 - the criminal justice process.
- g) Identify the services available for victims and survivors of sexual violence and abuse, including how they are funded,

- h) Identify the gaps in support,
- i) Analyse and report on findings,
- j) Make recommendations for future services.

This needs assessment was conducted by LimeCulture Community Interest Company utilising a mixed methodology that allowed their Project Team to seek clarification through investigation by reviewing key documentation and interviewing key personnel in order to meet the key aims of the needs assessment.

The delivery of the needs assessment consisted of a 3-phase process. Each phase is considered in detail below.

Phase 1: Documentary & Data Review

Key documentation review - key operational and management documentation relating to the commissioned services was provided to the Project Team by the Commissioners, which included service specifications and financial information. There was a thorough analysis and explanation of the information, evidence and intelligence that was provided to the Project Team. This was sense checked and tested with local stakeholders to ensure that the information that it provides is helpful to Commissioners. This component of the project framed the analytical process and provided contextual information about the circumstances that local support services have been operating within. The Project Team reviewed previous reports that have been completed for commissioners over the last few years. This included previous health needs assessments and reviews relevant to the local landscape either linked to or directly involving the needs of victims/survivors of sexual violence and abuse.

Data, including prevalence estimates from national statistics, police reported crime and local authority assessment and care planning data, as well as service level access data, was requested by the Project Team and analysed for information or themes that are relevant to the needs of victims/survivors of sexual violence.

Phase 2: Stakeholder Interviews & Focus Groups

Stakeholder interviews and focus groups brought a further level of intelligence to the needs assessment. Targeted discussions with the range of local Commissioners,

commissioned sexual violence support service providers, front line operational staff from the police, councils, NHS services and local voluntary sector services providing specialist support to victims/survivors of sexual violence and other local services was extremely beneficial to this process.

Stakeholder Interviews were conducted in order to seek to understand and explore the following and the findings on what effective responses look like we used to frame the recommendations.

- How and what services are currently delivered across Nottinghamshire;
- Specific needs of victims/survivors of sexual violence and how these are being met;
- Gaps in provision and where needs could be better targeted;
- What effective responses look like and how they can be achieved;
- Whether there are any operational barriers to accessing support.

A semi-structured question framework was developed and employed as a method to collect qualitative data from stakeholder interviews and focus groups. Interviews were conducted by the Project Team as either individual interviews or as small group interviews depending on subject matter. Information and data was analysed and key themes identified from interviews and focus groups.

The LimeCulture Project Team conducted more than 30 stakeholder interviews and focus groups during August and September 2019 including:

- Service managers and staff (including clinical managers) from commissioned therapeutic sexual violence support services supporting adult and child victims/survivors,
- Service managers and staff from ISVA and CHISVA services,
- Manager and clinical staff from adult SARC,
- Clinical lead and clinical staff from Paediatric SARC,
- Clinical managers and psychologists from IAPT services and Nottinghamshire Healthcare NHS Foundation Trust,
- Managers and staff from commissioned third sector services (including housing, substance misuse and domestic abuse support organisations),
- Managers and workers (including clinical staff) from (non-commissioned) survivors support organisations,
- Survivor advocates from the Nottinghamshire CSA Survivors Group,
- Police officers working in adult sexual offence investigation teams, child abuse investigation teams and Operation Equinox,

- Managers and staff from grassroots third sector organisations supporting vulnerable groups, such as refugees, sex workers, FGM and BMER groups,
- NHS England and NHS Improvement Midlands Mental Health & Sexual Health Project Managers (Sexual Assault and Abuse Services),
- CCG, Local Authority (including Public Health) and PCC commissioners

Phase 3: Seeking the views of victims/survivors of sexual violence and abuse in Nottinghamshire

Victims/survivors were an important stakeholder group who were prioritised as part of this needs assessment. It is notoriously challenging to gather the views and experiences of victim/survivors of sexual violence, particularly in relation to how they perceived support services. This is due to a range of reasons but is broadly accepted that once victims/survivors move on from support services, they tend not to remain engaged with those services. On 26 August 2019, LimeCulture launched an online survey for victim/survivors of sexual violence in Nottinghamshire. This online survey allowed service users to share their experiences, views and suggestions anonymously with the Project Team. This survey was shared via social media, and with local service providers to encourage their service-users to access the survey to allow them to make their views known to the Project Team. The survey was available until 23 September 2019 and responses from 53 individuals were received by the Project Team. Both qualitative and quantitative data was provided which was used to inform the findings of this report. Full quantitative data has been included in the Appendices of this report.

The Project Team also spoke directly to more than 50 victims/survivors of sexual violence through a number of focus groups facilitated by local support services. These groups included a range of:

- Survivors of adult sexual violence and child sexual abuse as part of the OPCC's SARC Reference Group,
- Survivors from Nottinghamshire CSA Survivors Group,
- Survivors accessing ISVA, CHISVA and sexual violence therapeutic support services in Nottinghamshire facilitated by ISAS, SHE-UK, NSVSS and Imara,
- Survivors using specialist third sector services including substance misuse, housing and domestic abuse services.

It is important to note that all of the stakeholders who were interviewed as part of this process were informed by the Project Team that while the information they provided may be contained in the report, they would not be personally identifiable from any of the information that they shared with us. As such, the authors of this report have not disclosed the source of any of the information, views or experiences expressed to us as part of the needs assessment. However, the Project Team endeavoured to triangulate evidence provided throughout the period of the review by cross-checking information from a range of sources wherever possible.

Key Findings

The key findings of this needs assessment have been ascertained by the Project Team through careful analysis of prevalence data relating to sexual violence, reported sexual offence data as well as data and information provided by a range of sexual violence support services. The Project Team has consulted widely to obtain views and experiences from a wide range of stakeholders (professionals and victims/survivors of sexual violence and abuse).

It is suggested that the key recommendations contained within the report are used by Commissioners to inform their decision-making around how service provision for victims/survivors in Nottinghamshire is configured, designed, and funded moving forward.

The commissioning landscape for services to support victims/survivors of sexual violence and abuse is complex, with different public authorities having responsibility for commissioning different services (or elements of services) that are accessed by victims/survivors of sexual violence and abuse.

The Project Team is aware that there has been a concerted effort by the range of local commissioning authorities to work together to improve the response to sexual violence across Nottinghamshire. However, the current governance structure should be reviewed to ensure that commissioning authorities are able to jointly monitor the implementation of the NHS Sexual Abuse and Assault Strategy, ensure equitable pathways to high quality support services are available across all of Nottinghamshire, and assure the effectiveness of commissioned specialist sexual violence support services through the monitoring of all relevant data.

It is notoriously difficult to quantify the true prevalence of sexual violence. This is due to difficulty in obtaining reliable information on the extent on sexual offences because of the under-reporting of these incidents. Despite the effort of police forces and other agencies to improve their response to victims of sexual violence, figures on sexual offences are heavily influenced by the willingness of victims/survivors to report.

It is clear, however, that victims/survivors of sexual violence and abuse present to a wide variety of services, including mainstream and services provided by the third sector, and at varying intervals after their assault. Many of these mainstream health, social care and third sector services are supporting individuals who are victims/survivors of sexual violence or abuse, although this is unlikely to be recorded. In addition, experiences of sexual violence is not included on data sets for such services, and therefore, there is no complete source of data that can be used to determine the level of need or demand on these services from victim/survivors.

The prevailing theme emerges from this needs assessment is recognition of the complexity of need belonging to this client group. The needs of victims/survivors of sexual violence are frequently 'multiple, changing and on-going'. The impact of sexual violence can be wide-ranging and devastate the lives of victims/survivors. However, victims/survivors of sexual violence are not a homogenous group and therefore individual needs will be different for each victim/survivor. It is, therefore, important to ensure that risk and needs assessments are conducted to identify the individual needs of each victim/survivor and ensure that support can be put in place to meet these needs.

There are currently a range of services commissioned by Local Authorities, PCC, CCGs and NHS England to provide exclusive support to victims and survivors of sexual violence and abuse. The Project Team is aware that the local commissioning authorities have entered into separate contracts with a range of providers to deliver specialist sexual violence support services (and at different timeframes), which has contributed to a number of different services being available for victims/survivors of sexual violence across Nottinghamshire.

The Project Team is of the view that these services should be jointly commissioned by the range of commissioners with responsibility (Local

Authorities, NHS England, PCC and CCGs) to ensure that there is a consistent approach to service provision and quality across the whole of Nottinghamshire (city and county), for adults and child victims of sexual violence and abuse, with different commissioning authorities taking the lead (on behalf of the other commissioners) for specific services or elements of service. Crucially, Commissioners should seek to better understand the capacity of the existing commissioned sexual violence support services by reviewing existing service specifications, seek clarity on waiting list arrangements, identifying the optimum number of staff required to effectively support victims/survivors in these services, taking on board prevalence data, reported sexual offences and access/demand trends on these services.

Due to the range and complexity of needs that victims/survivors might have, it is clear that the commissioned sexual violence support services cannot – and do not - provide the whole package of support required by victims/survivors of sexual violence, and there is a need for victims/survivors to access other services to address any wider needs they may have, which may include services addressing and responding to domestic abuse, physical, sexual and/or mental health needs, education/employment, housing, financial support and immigration support. As well as any special needs relating to personal characteristics which might include language, disability, religion.

It is, therefore, important that there are pathways of support put in place, with clear referral pathways, clarity on access criteria for such services, information sharing agreements formalised through service level agreements, between services to enable victims/survivors to have timely access to the services they need.

The creation of a 'coordination hub' was suggested as an opportunity to ensure that victims/survivors are able to access information and have their individual needs assessed, with onward referral to alternative or additional services to then meet these needs. The Project Team explored this idea further with a range of stakeholders, including victims/survivors and professionals from a range of services. Stakeholders described the benefit of a single 'coordination hub' that could provide the following:

- Helpline/Information (for victims/survivors and professionals)

- Referrals from professionals in other services e.g., drug and alcohol, housing, sexual health etc
- Self-referral from victims/survivors
- Assessment of risk and/or needs including mental health assessment
- Development of individuals support plans
- Coordination of referrals to (or delivery of) specialist sexual violence support services
- Coordination of referrals to other services to meet victim/survivors needs.

While this needs assessment identified that victims/survivors may each have differing range of needs, it clearly identified the impact of sexual violence on mental health and well-being. It is crucial that services to support victims/survivors of sexual violence with their mental health needs are made available. This needs assessment-identified problems for victims/survivors in accessing mental health services and the Project Team is of the view that more needs to be done to address the complex mental health needs of victims/survivors of sexual violence, who may not be getting the right level or type of support based on their needs. As such, this needs assessment recommends that mental health assessments should be available to all victims/survivors to determine their level of need and allow access to the right service including secondary mental health care and medication at the right time.

In addition, Commissioners should seek to better understand the capacity of specialist sexual violence services across Nottinghamshire in relation to the therapeutic services that are being provided. The Project Team recommends that Commissioners should review the provision and clinical effectiveness of the existing services, with clear service specifications put in place moving forward.

The Project Team is aware nationally that referrals to ISVA and CHISVA services continue to increase, particularly as their service becomes better known and understood by professionals in mainstream and third sector and by victims/survivors who may wish to self refer. The Project Team is concerned about the potential increase in demand for the ISVA and CHISVA services in Nottinghamshire.

This needs assessment also highlighted the need for awareness training amongst professionals in mainstream and third sector organisations about the impact of sexual violence and abuse, and include support around recognising

signs and symptoms of abuse. This needs assessment identified that some professionals do not always have the confidence to discuss sexual violence with their clients and are not always aware of the specialist sexual violence support services available across Nottinghamshire. Building on the work already started in the County, routine enquiry into sexual violence and abuse should be introduced across these services. This must be underpinned by adequate training and clear referral pathways to specialist sexual violence support services.

As part of this needs assessment, the LimeCulture Project Team has made the following recommendations:

Recommendation 1 - Current governance arrangement should be reviewed to ensure commissioning authorities are able to jointly monitor the implementation of the NHS Sexual Abuse and Assault Strategy, pathways of support (including referrals) across all of Nottinghamshire and the effectiveness of commissioned specialist sexual violence support services through the monitoring of all relevant data.

Recommendation 2 - Specialist sexual violence support services should be jointly commissioned by the range of commissioners with responsibility (Local Authorities, NHS England, PCC and CCGs) to ensure that there is a consistent approach to service provision and quality across the city and county for adults and child victims of sexual violence and abuse, with different commissioning authorities taking the lead (on behalf of the other commissioners) for specific services or elements of service.

Recommendation 3 - CCGs should fund sufficient mental health services and therapeutic support services for victims/survivors of sexual violence (including those delivered by the specialist sexual violence support services in the third sector).

Recommendation 4 - Commissioners should seek to better understand the capacity of the commissioned sexual violence support services by reviewing existing service specifications, seek clarity on waiting list arrangements, identifying the optimum number of staff required to effectively support victims/survivors in these services, taking on board prevalence data, reported sexual offences and access/demand trends on services.

Recommendation 5 - Commissioners should ensure that data is routinely and consistently collected by mainstream and third sector services about the number of service users accessing their services who have disclosed sexual violence. This could be implemented alongside awareness training for professionals (see below recommendation 6) and the introduction of routine enquiry (see below recommendation 7).

Recommendation 6 - Sexual violence awareness training should be delivered to staff in mainstream and third sector organisations about the impact of abuse, and include support around recognising signs and symptoms of abuse.

Recommendation 7 - Routine enquiry into sexual violence and abuse should be introduced across mainstream and third sector services. This must be underpinned by adequate training (see recommendation 6) and clear referral pathways to support.

Recommendation 8 - Information about specialist sexual violence support services should be communicated to mainstream and third sector organisations across Nottinghamshire. This should include access criteria and referral information.

Recommendation 9 - Explore better use of information sharing agreements to support victim/survivor engagement with mainstream and third sector services that reduces the need for the repeating of sensitive information. A common risk and needs assessment should be considered for use as part of this.

Recommendation 10 - Commissioners should consider adopting a 'coordination hub' to assess need, triage and manage referrals for victims/survivors of sexual violence across Nottinghamshire (City and County).

Recommendation 11 - Commissioners should review the commissioning arrangements for specialist sexual violence support services for child victims of sexual violence, particularly in light of the gap in provision for therapeutic support.

Recommendation 12 - Commissioners should monitor the effectiveness of specialist sexual violence support services in meeting the needs of older people who have experienced sexual violence and abuse.

Recommendation 13 - Commissioners (and providers) should routinely monitor the uptake of specialist sexual violence support services by BME communities, and take appropriate action to ensure services are available and meet the needs of victims/survivors from across Nottinghamshire's diverse and evolving community.

Recommendation 14 - Commissioners should review and monitor the provision of specialist sexual violence support services to ensure that they are meeting the needs of all genders of victims/survivors including male, transgender (trans-men/trans-women) and those who identify as gender-fluid.

Recommendation 15 - Commissioners should ensure that providers of specialist sexual violence support services are collecting and recording the sexuality of victims/survivors of sexual violence. This should be monitored to ensure the service is effective to meet their needs.

Recommendation 16- Commissioners should ensure that providers of specialist sexual violence support services are collecting and recording information about physical disability, learning disability and any communication support requirements. This should be monitored to ensure the service is effectively meeting the needs of these victims/survivors.

Recommendation 17 - Commissioners should ensure that a pathways of support is available to all victims/survivors of sexual violence which is accessible based on need rather than when the abuse took place. However, it will be important to establish timeframes to provide context and assess risk of harm from others.

Recommendation 18 - Commissioners should ensure that a pathways of support is available to all victims/survivors of sexual violence who are offenders, recognising the need to meet security requirements for support delivered within the prison estate.

Recommendation 19 - Commissioners should review the interface between IDVA services and ISVA services to ensure the victims/survivors of sexual violence in a domestic setting are appropriately supported. The Project Team recommend that this should be risk-focused, e.g., IDVAs lead on reducing the risk of

domestic abuse and then hand over to ISVAs to provide practical and emotional support around the sexual violence aspects.

Recommendation 20 - Commissioners should ensure that the sexual assault pathway includes support for child sexual exploitation that is available to child victims/survivors in both the city and county.

Recommendation 21 - Commissioners should consider ensuring ISVAs have additional training around supporting clients who may be involved in sex work.

Recommendation 22- Commissioners should ensure that there is clarity amongst the range of services (including specialist sexual violence support services, mainstream and third sector service) about the services provided by the Topaz Centre.

Recommendation 23 - Commissioners should ensure that referral pathways to and from the Topaz Centre and the Paediatric SARC are clearly defined and commutated with all key partners.

Recommendation 24 - Commissioners should ensure that delays to accessing medical examination are monitored effectively with plans put in place to avoid delays.

Recommendation 25 - Commissioners should ensure that victims/survivors have access to mental health assessments to accurately identify the level of need in relation to mental health.

Recommendation 26 - As part of the joint commissioning arrangements commissioners should review the provision, demand and clinical effectiveness of therapeutic support provided to victims/survivors of sexual violence. Clear service specifications should be developed.

Recommendation 27 Commissioners should ensure that the new Pre-trial therapy guidelines are understood and implemented across the specialist sexual violence support services and mental health services. Where possible, awareness should be raised amongst other stakeholders in the third and private sector.

Recommendation 28 - Referral pathways should be developed to allow victim/survivors of sexual violence with mental health needs to access the right services at the right time, and including to medication. This should include those with personality disorder and complex post-traumatic stress disorder.

Recommendation 29 – CCGs should review the findings from the IAPT pilot to inform commissioning decisions about the expansion of this service to other victims/survivors of sexual violence and abuse.

Recommendation 30 - Commissioners should consider piloting the use of personal health budgets to identify appropriate assessments of need and agreed clinical outcome measures to determine the appropriate range of support that could be purchased.

Recommendation 31 - Commissioners should review the provision of group therapy and agree a model of commissioning and delivery that provides a structured programme of support, with routine clinical outcome monitoring.

Recommendation 32 - Providers of sexual violence support services should develop relationships with drug and alcohol services to facilitate access to support. Co-delivery approaches should be explored to support victims/survivors of sexual violence who have drug and/or alcohol dependency.

Recommendation 33 - In order to support the safeguarding of children and adults at risk, commissioners should ensure that professionals are trained to the appropriate level as a pre-requisite of any contract or grant from a statutory authority. Commissioners should also monitor that professionals within these services are accessing regular (refresher) training on safeguarding.

Recommendation 34 - Commissioners should ensure that awareness is raised about the provision of specialist sexual violence support services amongst children's services and adult social care. Access criteria and referral pathways should be clearly defined and communicated.

Recommendation 35 - Commissioners (and providers) should review the referral process from the police to the ISVA/CHISA services to ensure that referrals are made in all appropriate cases.

Recommendation 36 - The Police and the ISVA/CHISVA services should work together to identify how they will operate together to support individual victims/survivors of sexual violence and abuse. This should include agreeing referral pathways, information sharing and agree operating practices.

Recommendation 37 - Commissioners should maintain a watching brief on the outcomes from the national end-to-end review of rape and serious sexual offending. Any recommendations should be recognised, considered and implemented locally where appropriate.

Recommendation 38 – Specialist sexual violence support services should identify and routinely assess the needs of victim/survivors of sexual violence relating to employment and/or education and coordinate referrals.

Recommendation 39 - The relationship between Sexual Violence Liaison Officer - SVLOs (in Nottingham University and Nottingham Trent University) and ISVA service should be developed with clear referral pathways, information sharing agreements and agreed operational practices.

Recommendation 40 - Universities should be included in any local strategic or operational groups that relate to sexual violence to ensure the support for students is not excluded from local plans.

Recommendation 41 - Commissioners should explore developing pathways (or colocation in the coordination hub as described in recommendation 10) to DWP benefits advise to ensure that the financial needs of victims/survivors are being met.

Recommendation 42 – Commissioners should ensure that specialist sexual violence support services are identifying and routinely assessing housing needs of victims/survivors of sexual violence and abuse. Referral Pathways to Housing Support services should be formalised, with information sharing agreements put in place.

Recommendation 43 - Awareness raising of specialist sexual violence support services would be beneficial to grassroots organisations supporting those with immigration needs to increase referrals and provide support.

Recommendation 44 - Nottingham and Nottinghamshire Modern Slavery Partnership should be asked to inform commissioners with responsibility for sexual violence and abuse if there is any intelligence around increase prevalence/activity that could inform future commissioning.

Part 1: About this Needs Assessment

Chapter 1. Scope

- 1.1 In late July 2019, the Police and Crime Commissioner for Nottinghamshire (PCC) and NHS England & NHS Improvement Midlands commissioned LimeCulture Community Interest Company (CIC) to undertake a Mental, Physical and Sexual Health, Social and Economic Needs Assessment for Sexual Violence and Abuse Survivors in Nottinghamshire.
- 1.2 The purpose of the needs assessment is to inform the commissioning of services by identifying the needs of sexual violence and abuse survivors, the support services required and the likely demand in Nottingham and Nottinghamshire.
- 1.3 The objectives of the needs assessment (as set out in the specification document) are to:
 - a) Identify the prevalence, need and demand relating to sexual violence and abuse,
 - b) Identify the presenting needs of survivors who are accessing specialist and generic voluntary and public sector support services, specifically capturing data about multiple and complex needs where this is available,
 - c) Work with a wide range of community groups and public and voluntary sector providers to gather views from survivors of different types of sexual violence and abuse about their needs,
 - d) Facilitate a focus group/focus groups with a range of professionals from NHS services and specialist voluntary sector sexual violence services to determine health needs and how they are best met,
 - e) Facilitate (a) discussion/s with practitioners and stakeholders from public and voluntary sector services about survivors' health, wellbeing, social and economic needs and how best to meet them,
 - f) Consider and identify needs across all elements of survivors' pathway, including but not limited to:
 - crisis support,
 - health and well being needs specifically including sexual health

and mental health needs including counselling and therapeutic services,

- economic and social needs,
- the criminal justice process.

- g) Identify the services available for victims and survivors of sexual violence and abuse, including how they are funded,
- h) Identify the gaps in support,
- i) Analyse and report on findings,
- j) Make recommendations for future services.

1.4 It is important to note that this needs assessment did not include any review or evaluation of any services that are available, being provided or accessed by victims/survivors of sexual violence and abuse in Nottinghamshire. As such, LimeCulture CIC is not in a position to make an assessment as to the quality, efficacy or appropriateness of any of the services who may be accessed by victims/survivors of sexual violence and abuse.

1.5 As part of its regional work to support the implementation of the national Strategic direction for sexual assault and abuse services, NHS England /NHS Improvement (Midlands) has commissioned mapping of the services for victims and survivors across 2 areas - sexual health and mental health. This work includes recommendation around service improvement and commissioning. The findings from this work have been shared with key partners across the region and once published should be considered alongside this report.

Definitions

1.6 'Sexual abuse' and 'sexual violence' are often used inter-changeably, with 'sexual abuse' generally thought to cover a wider range of behaviours than 'sexual violence'.

1.7 In its recent Strategic Direction for Sexual Assault and Abuse Services, NHS England NHS Improvement Midlands includes rape and sexual violence within the wider terms 'sexual assault and sexual abuse'. It gives examples including: 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.

- 1.8 This need assessment refers to both sexual violence and abuse, which includes child sexual abuse.
- 1.9 The Independent Inquiry into Child Sexual Abuse (IICSA) has a Victims and Survivors Consultative Panel which has specifically requested the term victim and survivors of non recent child sexual abuse is used to refer to any abuse which took place in the past (rather than 'historical').

Part 1. About this Needs Assessment

Chapter 2: Methodology

- 2.1 This needs assessment was conducted by LimeCulture Community Interest Company utilising a mixed methodology that allowed their Project Team to seek clarification through investigation by reviewing key documentation and interviewing key personnel in order to meet the key aims of the needs assessment.
- 2.2 The delivery of the needs assessment consisted of a 3-phase process. Each phase is considered in detail below.

Phase 1: Documentary & Data Review

- 2.3 Key documentation Review - Key operational and management documentation relating to the commissioned services were provided to the Project Team by the Commissioners, which included service specifications and financial information. There was a thorough analysis and explanation of the information, evidence and intelligence that was provided to the Project Team. This was sense checked and tested with local stakeholders to ensure that the information that it provides is helpful to Commissioners. This component of the project framed the analytical process and provided contextual information about the circumstances that local support services have been operating within. The Project Team reviewed previous reports that have been completed for commissioners over the last few years. This included previous health needs assessments and reviews relevant to the local landscape either linked to or directly involving the needs of victims/survivors of sexual violence and abuse.
- 2.4 Data, including prevalence estimates from national statistics, police reported crime and local authority assessment and care planning data, as well as service level access data, was requested by the Project Team and analysed for information or themes that is relevant to the needs of victims/survivors of sexual violence.

Phase 2: Stakeholder Interviews & Focus Groups

- 2.5 Stakeholder interviews and focus groups brought a further level of intelligence to the needs assessment. Targeted discussions with the range of local Commissioners, commissioned sexual violence support service providers, front line operational staff from the police, councils, NHS services and local voluntary sector services providing specialist support to victims/survivors of sexual violence and other local services was extremely beneficial to this process.
- 2.6 Stakeholder Interviews were conducted in order to seek to understand and explore the following and the findings on what effective responses look we used to like frame the recommendations.
- How and what services are currently delivered across Nottinghamshire;
 - Specific needs of victims/survivors of sexual violence and how these are being met;
 - Gaps in provision and where needs could be better targeted;
 - What effective responses look like and how they can be achieved;
 - Whether there are any operational barriers to accessing support.
- 2.7 A semi-structured question framework was developed and employed as a method to collect qualitative data from stakeholder interviews and focus groups. Interviews were conducted by the Project Team as either individual interviews or as small group interviews depending on subject matter. Information and data was analysed and key themes identified from interviews and focus groups.
- 2.8 The LimeCulture Project Team conducted more than 30 stakeholder interviews and focus groups during August and September 2019 including:
- Service managers and staff (including clinical managers) from commissioned therapeutic sexual violence support services supporting adult and child victims/survivors,
 - Service managers and staff from ISVA and CHISVA services,
 - Manager and Clinical staff from adult SARC,
 - Clinical Lead and clinical staff from Paediatric SARC,
 - Clinical managers and psychologists from IAPT services and Nottinghamshire Healthcare NHS Foundation Trust,

- Managers and staff from commissioned third sector services (including housing, substance misuse and domestic abuse support organisations),
- Managers and workers (including clinical staff) from (non-commissioned) survivor support organisations,
- Survivor advocates from the Nottinghamshire CSA Survivors Group,
- Police Officers working in adult sexual offence investigation teams, child abuse investigation teams and Operation Equinox,
- Managers and staff from grassroots third sector organisations supporting vulnerable groups, such as refugees, sex workers, FGM and BMER groups,
- NHS England and NHS Improvement Midlands Mental Health & Sexual Health Project Managers (Sexual Assault and Abuse Services),
- CCG, Local Authority (including Public Health) and PCC commissioners

Phase 3: Seeking the views of victims/survivors of sexual violence and abuse in Nottinghamshire

2.9 Victims/survivors were an important stakeholder group who were prioritised as part of this needs assessment. It is notoriously challenging to gather the views and experiences of victim/survivors of sexual violence, particularly in relation to how they perceived support services. This is due to a range of reasons but is broadly accepted that once victims/survivors move on from support services, they tend not to remain engaged with those services. On 26 August 2019, LimeCulture launched an online survey for victim/survivors of sexual violence in Nottinghamshire. This online survey allowed service users to share their experiences, views and suggestions anonymously with the Project Team. This survey was shared via social media, and with local service providers to encourage their service-users to access the survey to allow them to make their views known to the Project Team. The survey was available until 23 September 2019 and responses from 53 individuals were received by the Project Team. Both qualitative and quantitative data was provided which was used to inform the findings of this report. Full quantitative data has been included in the Appendices of this report.

2.10 In addition, the Project Team spoke directly to more than 50 victims/survivors of sexual violence through a number of focus groups facilitated by local support services. These groups included a range of:

- Survivors of adult sexual violence and child sexual abuse as part of the PCC's SARC Reference Group,
- Survivors from Nottinghamshire CSA Survivors Group,
- Survivors accessing ISVA, CHISVA and sexual violence therapeutic support services in Nottinghamshire facilitated by ISAS, SHE-UK, NSVSS and Imara,
- Survivors using specialist third sector services including substance misuse, housing and domestic abuse services.

2.11 It is important to note that all of the stakeholders who were interviewed as part of this process were informed by the Project Team that while the information they provided may be contained in the report, they would not be personally identifiable from any of the information that they shared with us. As such, the authors of this report have not disclosed the source of any of the information, views or experiences expressed to us as part of the needs assessment. However, the Project Team endeavoured to triangulate evidence provided throughout the period of the review by cross-checking information from a range of sources wherever possible.

Part 2. Context

Chapter 3: National and Local context

National Policy Context

- 3.1 The Independent Inquiry into Childhood Sexual Abuse (IICSA) was established in 2015 to look into how Institutions in England and Wales handled their duty of care to protect children from sexual abuse. Later that year, IICSA announced one of its investigations would be into children in the care of Nottinghamshire councils. IICSA's Nottingham Hearing was held in October 2018 and the report outlining the findings was published in July 2019, with formal recommendations made for the City and County Councils.
- 3.2 The Government's Violence Against Women and Girls Strategy¹, published in 2016, recognises the gendered nature of sexual violence and child sexual abuse and sets out a framework of prevention, service provision, partnership working and pursuing perpetrators. Recent refreshes of the Strategy² (2019) and accompanying Action Plan³ include a position paper⁴ on male victims and survivors, recognising that whilst sexual violence is a gendered crime, boys and men are victims too with their own specific support needs.
- 3.3 NHS England published a Strategic Direction for Sexual Assault and Abuse Service (SAAS Strategy)⁵ in April 2018. It provides a national vision to radically improve access to services for victims and survivors of sexual

1
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/522166/VAWG_Strategy_FINAL_PUBLICATION_MASTER_vRB.PDF

2
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783596/VAWG_Strategy_Refresh_Web_Accessible.pdf

3
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783190/VAWG_Progress_Update_Web_Accessible.pdf

4
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/783996/Male_Victims_Position_Paper_Web_Accessible.pdf

5
<https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

assault and abuse and support them to recover, heal and rebuild their lives. The SAAS Strategy includes the need to strengthen prevention, promote safeguarding and welfare of victims and survivors, involve victims and survivors, introduce quality standards, reduce fragmentation and ensure an appropriately trained workforce. It also sets out commissioning responsibilities.

- 3.4 The Project Team is aware that the Government is currently planning to publish a Child Sexual Abuse Strategy sometime during 2019/20. It is expected that this will be a comprehensive strategy to include child victims/survivors of sexual violence and abuse, as well as adult victims/survivors of childhood sexual abuse and will focus on prevention, protection and support.

Local context

- 3.5 The Nottinghamshire Police and Crime Plan 2018-21⁶ sets out the Police and Crime Commissioner's intentions to achieve safer communities and improve trust and confidence in high quality policing by reducing crime and anti-social behaviour, ensuring fairer treatment of victims and citizens and demonstrating using public resources wisely. The plan includes a specific commitment to helping and supporting victims.
- 3.6 Nottinghamshire PCC was announced as one of 5 areas selected for the Ministry of Justice pilot for devolution of its Rape Support Fund. This pilot allows the PCC to determine how this funding is spent locally in Nottinghamshire on sexual violence support during 2019/20.
- 3.7 Since Summer 2017 the PCC has employed and part-funds alongside the City and County Councils a Sexual Violence Engagement Manager whose role is to enable adult victims/survivors of child sexual abuse which took place in institutional settings to communicate with support organisations and at a strategic level to ensure survivor voices are heard and used to develop improved service delivery.

⁶ <https://www.nottinghamshire.pcc.police.uk/Document-Library/Public-Information/Police-and-Crime-Plan/New-Plan-2018-2021/Police-and-Crime-Plan-2018-2021.pdf>

- 3.8 In 2014 for Nottinghamshire County the 'Nottinghamshire JSNA on Sexual Abuse' was published. It found clear evidence of the need to intervene earlier to prevent further health and wellbeing implications for survivors and identified gaps in service, in particular the coverage of Independent Sexual Violence Advocate provision across the county, levels of specialist therapeutic services to meet demand and early intervention and prevention work.

In Nottinghamshire County, the Framework for Tackling Domestic and Sexual Abuse in Nottinghamshire 2016-20 was developed by the County's Domestic and Sexual Abuse Executive under the umbrella of the Health and Wellbeing Board. Its vision is: 'A Nottinghamshire where everyone lives free from domestic and sexual abuse'.

- 3.9 In Nottingham City, a Domestic and Sexual Violence and Abuse JSNA was published in 2018 which includes the need for sexual violence support services to be appropriately linked into mental health services, the need to develop a common understanding of clinical therapeutic needs and how best to meet them and the need for health and social care providers to ensure that all staff are adequately trained to encourage disclosure and respond effectively.

In Nottingham City the Sexual Violence Action Network (SVAN) was created to ensure an effective partnership response to Sexual Violence and Abuse in the City. The SVAN is made up of the statutory and voluntary sector organisations, who focus their work and activities on sexual violence and specialist support. Most recently the SVAN has designed and developed the Consent Coalition. This will be the branding for all the SVAN's public sexual violence activities including a website (launching in January 2020) booklet, consent social media campaign as well as a survey around sexual violence and consent. These projects aim to raise awareness of sexual violence, support services and reporting pathways in Nottingham City.

- 3.10 In late 2014 a City/County/Health/Police Senior Management Group (SMG) was established, in line with the Nottingham and Nottinghamshire local safeguarding board procedures for complex and historical abuse

(now termed non-recent abuse), and in response to Police Operations Daybreak and Xeres (which later became Operation Equinox). The SMG agreed a Historical Child Abuse Victim and Survivor Support Strategy in 2016. The CSA Survivor Group also formed and agreed terms of reference in 2016.

Part 2: Context

Chapter 4: Commissioning Responsibilities

National commissioning landscape

- 4.1 The commissioning landscape for services to support victims/survivors of sexual violence and abuse is complex, with different public authorities having responsibility for commissioning different services (or elements of services) that are being accessed by victims/survivors of sexual violence and abuse.
- 4.2 NHS England's Strategic Direction for Sexual Abuse and Assault Services (2018) provides detail about the range of authorities with responsibility for commissioning services for victims/survivors of sexual violence and abuse.

Figure 1: Responsibilities of Commissioning Authorities

NHS England/NHS Improvement

- Sexual Assault Referral Centres (SARCs) responsible for forensic medical examinations, medical care/support and follow up services in SARCs with PCC and 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 (CCG)

- 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 (PCC)

- 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 peoples 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 child sexual abuse

4.3 The Government's Violence Against Women and Girl's Strategy (2016-2020) identifies that the best local areas are taking a strategic approach to their responsibility for ensuring support is available and:

- Carry out evidence-based assessments of need, drawing on the best available data;
- Base commissioning on their local needs assessment and the best available evidence of what works, innovating where necessary to meet new or complex challenges;
- Pool budgets across different agencies to make best use of available resources;
- Design coherent pathways of support and incorporating innovative approaches
- Involve local third sector organisations in commissioning, recognising that they have important insight into victims' needs
- Show strong leadership supported by clear local accountability for service provision;
- Collaborate across local authority and service boundaries, recognising that provision must be flexible to meet victims/survivors' needs.

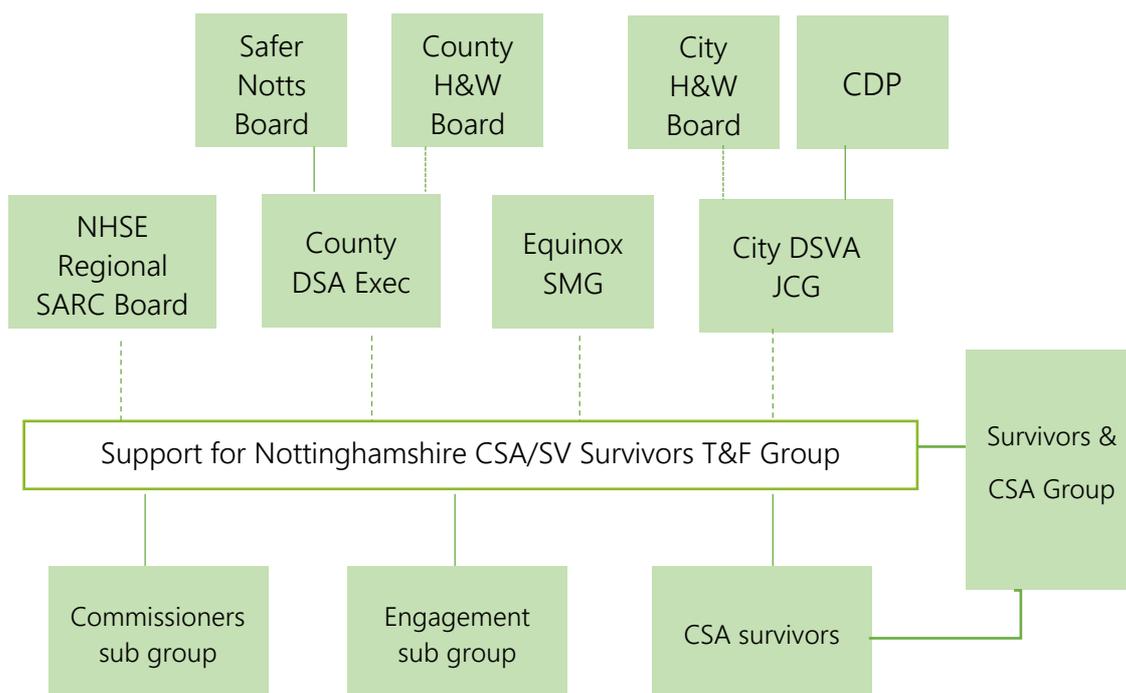
Local Governance Arrangements

4.4 The Project Team is aware that there has been a concerted effort by the range of local commissioning authorities to work together to improve the response to sexual violence across Nottinghamshire. This includes the PCC working closely with clinical commissioning groups, local authorities and NHSE/NHSI to develop a joint commissioning approach for services to support victims/survivors of sexual violence and abuse.

4.5 The Project Team was informed that a range of Strategic and Commissioning Groups exist to oversee the sexual violence commissioning arrangements. These include:

- Regional SARC Board – this is chaired by NHS England and brings together PCCs from the East Midlands. It focusses primarily on the performance of SARCs across the region, however, also has a role to oversee the implementation of the SAAS in the East Midlands.
- Nottingham DSVA Joint Commissioning Group (JCG)- where Nottingham City Council including public health, Nottingham CCG, the PCC and NHS England have agreed to work together jointly, to develop and implement joint commissioning arrangements in accordance with the city’s DSVA strategy. The JCG reports into the Crime and Drugs Partnership (Nottingham’s community safety partnership) and the Health and Wellbeing Board. It focuses on domestic abuse and sexual violence.
- In the county there is a Domestic and Sexual Abuse Executive, which is led by the County Council Director of Public Health and brings together a wide range of community safety partners including district councils, CCGs, the PCC, probation agencies, children’s services NHS England and commissioned providers. The DSA Executive reports to the Safer Nottinghamshire Board, which is the county’s umbrella community safety partnership, and the Health and Wellbeing Board.
- The Equinox Senior Management Group (SMG) which oversees the support for adult survivors of non recent CSA which took place whilst the children were in the care of authorities.
- Following a PCC chaired meeting with senior stakeholders from the SMG, a CSA/SVA Task and Finish Group was established with aims to plan for future support services. It is chaired by the CCGs and reports into the Senior Management Group as well as indirectly to the community safety partnerships and health and wellbeing boards. It has a strategy which includes objectives to empower survivors to cope and recover and to ensure that services are equitable.

Figure 2: Simplified diagram of the local governance (provided by PCC).



Local Commissioning Arrangements

- 4.6 There are currently a range of services commissioned by Local Authorities, PCC, CCGs and NHS England to provide exclusive support to victims and survivors of sexual violence and abuse. These commissioned services are delivered by specialist sexual violence third sector organisations and are referred to in this needs assessment as “specialist sexual violence support services”.
- 4.7 The Project Team is aware that the local commissioning authorities have entered into separate contracts with a range of providers to deliver specialist sexual violence support services (and at different timeframes), which has contributed to a number of different services being available for victims/survivors of sexual violence across Nottinghamshire.
- 4.8 Some of these specialist sexual violence support services are county-wide (i.e., a single service available to victims/survivors from across the whole of Nottinghamshire). These services include:
- Adult SARC,
 - Paediatric SARC,

- ISVA service,
- CHISVA service,
- Survivors Support Service (for adult victims/survivors of non-recent CSA which took place whilst they were in the care of authorities)

4.9 In addition to these county-wide services, other specialist sexual violence support services that have been commissioned to provide support for smaller population groups (largely coterminous with the City or County Council boundaries or a CCG boundary (i.e. sexual violence pilot in an IAPT service). As Local Authorities and CCGs are responsible for commissioning services for the populations of specific geographical areas⁷, there are different services being delivered across different areas that make up Nottinghamshire.

4.10 The therapeutic support contracts are largely historic arrangements with extensions being made to existing providers. These include:

- Therapeutic support for 13+
- Therapeutic support for 16+
- Therapeutic support for children and young people.

4.11 The below table identifies the commissioned specialist sexual violence support services across Nottinghamshire.

Figure 3 Commissioned Sexual Violence Support Services

Specialist sexual violence support service	Scope	Provider	Area	Funded 2019/20
Adult SARC	Adults	Mountain Healthcare	City/County	NHS England PCC Nottinghamshire Police
East Midlands Paediatric SARC (regional)	Children	Nottingham University Hospital NHS Trust (subcontract Imara & Notts SVSS)	City/County	NHS England Nottinghamshire Police Other PCCs in the East Midlands

⁷ Two local authorities cover Nottingham City (unitary) and Nottinghamshire County (two tier authority). 6 CCGs have recently come together as 'Nottinghamshire CCGs', this includes Mansfield and Ashfield, Newark and Sherwood, Nottingham City, Nottingham North and East and Rushcliffe. Bassetlaw CCG is outside the arrangement and makes its own commissioning decisions.

ISVA service	Adults	Notts SVSS	City/County	PCC County Council Home Office VAWG funding
Survivor Support Service	Adults	Notts SVSS	City/County	PCC City Council County Council
CH-ISVA service	Children	Imara	City/County	PCC
SV and Non-Recent Abuse therapeutic support	13+	Notts SVSS	City/County	PCC County
SV therapeutic support	13+	ISAS	County	PCC County Council Bassetlaw CCG
SV therapeutic support	13+	Notts SVSS	City/County	PCC (MoJ Devolved)
SV therapeutic support	13+	SHE-UK	County	PCC (MOJ Devolved) County Council
SV therapeutic support	16+	Notts SVSS	County	PCC Nottingham CCG City Council
SafeTime therapeutic support commissioned jointly with SafeChoices (CSE intervention programme)	Children	Children's Society	County	County Council County CCGs

4.12 It is important to note that there are also a range of other mainstream or third sector organisations who are commissioned to deliver other services, such as sexual health services, mental health services, alcohol and drug services etc, which are accessed by victims/survivors of sexual violence but are not specifically commissioned to provide a dedicated service to this client group.

4.13 Improving Access to Psychological Therapies (IAPT) Services provide Step 2 (low) and Step 3 (high) intensity psychological therapy. The workforce includes CBT therapists and counsellors, though the makeup within services varies by provider;

- Nottinghamshire County CCGs (excluding mid Notts and Bassetlaw) - Let's Talk Wellbeing, Trent PTS and Insight

- Nottingham City CCG - (Let's Talk Wellbeing, Trent PTS and Insight)
- Mid Notts (Mansfield and Ashford) CCGs - Insight
- Bassetlaw CCG - Insight

4.14 IAPT Step 4 Psychology/Psychotherapy Services are provided by Nottinghamshire Healthcare NHS Foundation Trust (NHNFT). However, there is inequitable access to Step 4 services as these areas have not all been commissioned comparably by CCGs. Generally, Step 4 is provided by psychologists and psychotherapists and with some provision within local mental health teams. Access is via GP or self referral.

4.15 NHNFT also provide a range of inpatient and outpatient community services for those with mental health conditions this include community mental health teams and crisis teams. However access to these services is via GP referral (se Section 13.6).

4.16 The Mandala Centre: Centre for Trauma Resilience and Growth work with adults who have been exposed to a variety of traumatic events. This includes serious crime, road traffic collisions or industrial accidents, victims of domestic violence and sexual abuse or torture, as well as individuals affected by occupational related trauma. It is accessed via GP referral. There are currently limited numbers of those who have experienced sexual assault being supported by the service. It is currently awaiting funding decisions and is closed to new referrals.

4.17 The Recovery College is accessible to those receiving treatment by secondary care mental health services. It provides a range of courses and groups which victims/survivors can access to support their mental health and wellbeing.

4.18 There are sexual health clinics within the NHS that are accessed by victim/survivors of sexual violence and abuse for their sexual health needs, including STIs, contraception and termination of pregnancy services.

4.19 There are a range of non commissioned third sector services reporting that they support victims/survivors of sexual violence, either as an exclusive service to this cohort or indirectly - ie, they provide other support that is

relevant to the wider needs of victim/survivors of sexual violence and abuse. These include:

- Human Flourishing Project
- Nottingham Counselling Centre
- Nottingham Refugee Forum
- Nottingham Muslim Women's Network
- Support for Survivors
- Chayah
- BAC-IN
- POW
- Building Bridges Breaking Barriers
- Eden Hearts

Part 3: Prevalence and Demand

Chapter 5: Prevalence of sexual violence and abuse

- 5.1 It is difficult to quantify the true prevalence of sexual violence. This is due to obtaining reliable information on the extent on sexual offences because of the under-reporting of these incidents. Despite the effort of police forces and other agencies to improve their response to victims of sexual violence, figures on sexual offences are heavily influenced by the willingness of victims to report.
- 5.2 Victims of sexual violence present to a wide variety of public and third sector services at varying intervals after their assault. In addition, many public and third sector services will be dealing with individuals who are victims of sexual violence or abuse, although this may not be disclosed and therefore is unlikely to be recorded. Therefore, there is no complete source of data that can be used to determine the prevalence of sexual violence and abuse.

Estimating Prevalence from National Data Sets

- 5.3 The Crime Survey for England and Wales (CSEW) collects information on sexual assaults via self-completion modules of all adult respondents aged 16 to 59 years resident in households in England and Wales. Sexual assaults measured by the CSEW cover:
- rape (including attempts)
 - assault by penetration (including attempts)
 - causing sexual activity without consent⁵
 - indecent exposure
 - unwanted touching
- 5.4 It is important to note that the CSEW term 'sexual assault' differs from the term 'sexual assault' in police recorded crime, Crown Prosecution and Ministry of Justice data.

5.5 There are two time periods of sexual assaults routinely covered by the CSEW:

- experiences since the age of 16 years
- experiences in the 12 months prior to interview.

5.6 Data from a self-completion module in the CSEW for the year ending March 2019 showed that 2.9% of adults aged 16 to 59 years had been victims of sexual assaults in the last year (including attempted offences). For men this figure is 1.2% and for women 4.5%. This estimate showed no significant change compared with the previous year (2.7%)

Estimating the Prevalence of Sexual Assault in Nottinghamshire

5.7 The data presented below relates to 2017/18 population statistics for Nottinghamshire using the CSEW prevalence estimates. Updated population statistics at local authority level have not yet been released for 2019. Note: no adjustment has been made here for the differing demographics of population ethnicity, deprivation for Nottinghamshire. A further breakdown by City/County is shown in Appendix E.

Recent Sexual Violence (Adults)

Figure 4 Prevalence Rates of sexual assault from the Crime Survey England and Wales 2018⁸

Estimated percentage of the population experiencing sexual assault by type		Since the age of 16			In the last 12 months		
		Men	Women	All	Men	Women	All
Sexual assault including attempts	Serious sexual assault	0.5	7.7	4.1	0.1	0.9	0.5
	Rape	0.4	6.9	3.6	0.0	0.7	0.4
	Less serious sexual assault	4.4	23.3	13.8	1.2	3.8	2.5
	Sexual assault by a partner	0.7	6.3	3.5	0.1	0.4	0.2
	Sexual assault by a family member	0.2	1.9	1.0	0.0	0.1	0.1
	Any sexual assault	4.5	24.3	14.4	1.2	4.2	2.7
Sexual assault excl	Serious sexual assault	0.4	6.3	3.3	0.0	0.7	0.4
	Rape	0.4	5.7	3.0	0.0	0.4	0.2
	Assault by penetration	0.2	4.1	2.1	0.0	0.4	0.2

⁸ Table S34: Prevalence of intimate violence among adults aged 16 to 59, by category, year ending March 2018 CSEW¹
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwalesappendixtables>

attempts							
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Figure 5 Prevalence of sexual assault from the Crime Survey England and Wales 2018 applied to Mid Year Population Estimates for 2018⁹

Estimated numbers of the population experiencing sexual violence in Nottinghamshire		Since the age of 16			In the last 12 months		
		Men	Women	All	Men	Women	All
Sexual assault including attempts	Serious sexual assault	1,531	25,769	27,148	218	3,035	3,235
	Rape	1,340	22,961	24,162	166	2,252	2,404
	Less serious sexual assault	14,715	77,568	91,943	3,920	12,776	16,648
	Sexual assault by a partner	2,359	20,970	23,175	262	1,207	1,461
	Sexual assault by a family member	570	6,309	6,847	168	447	614
	Any sexual assault	15,271	80,932	95,807	4,067	14,107	18,109
Sexual assault excluding attempts	Serious sexual assault	1,332	21,074	22,425	166	2,194	2,361
	Rape	1,261	19,063	20,311	166	1,476	1,641
	Assault by penetration	827	13,546	14,371	87	1,331	1,418

Adults' Experience of Child Sexual Abuse

5.8 In 2016¹⁰, a self-report module within the CSEW was added as a one off to allow individuals to identify whether they had experienced sexual abuse in childhood. Using this data, the Project Team is able to provide an estimate of the prevalence of child sexual abuse experienced by adults. However, it is not possible to estimate the prevalence of particular forms of abuse e.g. familial or institutional for example. A further breakdown by City/County is shown in Appendix E.

⁹ ONS Mid Year Population Estimates for 2018
<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalescotlandandnorthernireland>

¹⁰ Table A4a: Proportion of adults who experienced abuse during childhood by abuse type and personal characteristics, year ending March 2016 CSEW
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/abuseduringchildhoodappendixtable>

Figure 6 Proportion of Adults in Nottinghamshire who experienced sexual assault during childhood by type of sexual assault and personal characteristics

Age	Prevalence			Numbers of adults		
	Any sexual assault (%)	Sexual assault by rape or penetration (inc attempts)	Other sexual assault	Any sexual assault	Sexual assault by rape or penetration (inc attempts)	Other sexual assault
All Adults	6.6	2.0	6.3	41,858	13,465	43,401
16-24	3.0	0.8	2.9	3,255	1,296	4,551
25-34	4.9	1.8	4.6	4,507	2,540	7,047
35-44	7.3	2.6	6.9	6,476	3,571	10,046
45-54	9.2	2.7	9.0	10,328	4,221	14,549
55-59	9.4	2.2	9.1	13,748	4,236	17,984

Figure 7 Proportion of Adults in Nottinghamshire who experienced sexual assault during childhood by type of sexual assault and age



5.9 It should be noted that the CSEW prevalence data shows that the younger respondents are less likely to have experienced sexual abuse during childhood.

Child Sexual Abuse

- 5.10 A review published in the Lancet (Gilbert 2008)¹¹ estimated that between 5% and 10% of girls and 5% of boys have experienced penetrative sexual abuse before the age of 18, and up to three times this number may have experienced other forms of sexual violence. The NSPCC study (NSPCC 2011)¹² reviewed 28 prevalence studies and found rates across the studies ranging from 1.1% to 32% for lifetime experiences of childhood sexual abuse.
- 5.11 While estimates of lifetime prevalence of child sexual abuse vary considerably among reports, even less is known about rates of past year child sexual abuse, which is crucial for assessing the immediate need of the local population and for establishing appropriate paediatric services for supporting victims of sexual abuse.
- 5.12 One study that has attempted to calculate rates of past year experience of child sexual abuse is that of the NSPCC (Radford, 2011)¹³. They carried out interviews with 2,160 parents or guardians of children and young people aged 10 years and under and 2,275 young people between the ages of 11 and 17, with additional information provided by their parents or guardians and 1,761 young adults between the ages of 18 and 24. They found that in the previous year, 0.6% of under 11 year olds and 9.4% of 11 to 17 year olds had experienced some form of sexual abuse (including non contact offences). They estimate that in the past year 0.2% of children aged 10 and under and 1.9% of 11 to 17 year olds had experienced contact sexual abuse.

Figure 8 Lifetime (LT) and Past Year (PY) experience of sexual abuse ¹⁴

Percentage of those experiencing sexual	Under 11years (LT)	Under 11 years (PY)	11-17 years (LT)	11-17 years (PY)	18-24 years (LT)

¹¹ Gilbert, Widom, Browne, Fergusson, Webb (2008) Burden and consequences of child maltreatment in high-income countries CHILD MALTREATMENT| VOLUME 373, ISSUE 9657, P68-81, JANUARY 03, 2009

¹²Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

¹³ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

¹⁴ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

abuse					
Contact Sexual Abuse	0.5%	0.2%	4.8%	1.9%	11.3%
Estimated Any Sexual Abuse (including non-contact)	1.2%	0.6%	16.5%	9.4%	24.1%

5.13 Of the 11–17s who reported adult perpetrated contact sexual abuse: 75.5 per cent reported a known, 18.8% and 3.8% both a known and unknown perpetrator. Of the 18–24s who reported adult perpetrated contact sexual abuse in their lifetime: 90.2 per cent reported a known, 5.2% an unknown, and 4.6% both a known and unknown perpetrator. The same report shows that 65.9% of contact sexual abuse reporting by children and young people is perpetrated by other children and young people under 18.

Figure 9 Estimated numbers of children who experience child sexual abuse annual in Nottinghamshire Police Force Area (PFA)

Age	Nottingham City			Nottinghamshire County			All Nottingham PFA	
	Population	Contact Sexual Abuse	Non-Contact Sexual Abuse	Population	Contact Sexual Abuse	Non-Contact Sexual Abuse	Contact Sexual Abuse	Non-Contact Sexual Abuse
10 and under	44,885	90	539	104,284	209	1,251	299	1,790
11-17	20,324	386	1,910	53,402	1,015	5,020	1,401	6,930
Totals	65,209	476	2,449	157,686	1,223	6,271	1700	8,720

5.14 Using this prevalence information and the Mid-Year Population Estimates for 2018¹⁵ we can estimate the number of children and young people across Nottinghamshire who experience contact sexual abuse in the last year as 299 children aged 10 years and under and 1,401 children and young people aged 11 to 17 years. A further 8,720 children are estimated to experience non-contact sexual abuse which should still form the basis of assessment by social care. A further breakdown by City/County is shown in Appendix E.

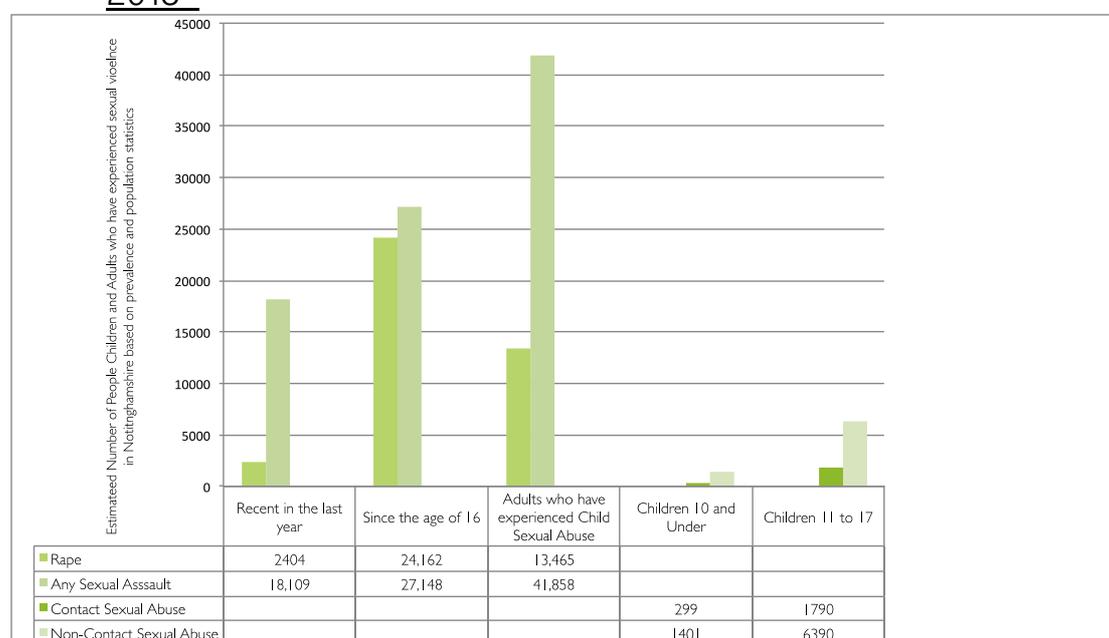
¹⁵ ONS Mid-Year Population Estimates for 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesandnorthernireland>

Experience of Sexual violence in Nottinghamshire

5.15 The graph below shows the estimated numbers of individuals experiencing sexual violence in Nottinghamshire, which is based on CSEW prevalence and population statistics (Adults and Children). A further breakdown by City/County is shown in Appendix E.

Figure 10 Estimated numbers of victims and survivors of sexual violence in Nottinghamshire Police Force Area extrapolated from the Crime Survey England and Wales 2016¹⁶ 2018¹⁷ and NSPCC¹⁸ report applied to Mid Year Population Estimates for 2018¹⁹



¹⁶ Table A4a: Proportion of adults who experienced abuse during childhood by abuse type and personal characteristics, year ending March 2016 CSEW

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/abuseduringchildhoodappendixtable5>

¹⁷ Table S34: Prevalence of intimate violence among adults aged 16 to 59, by category, year ending March 2018 CSEW¹

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwalesappendixtables>

¹⁸ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC

<https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

¹⁹ ONS Mid Year Population Estimates for 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesandnorthernireland>

Harmful Sexual Behaviour

- 5.16 It should be noted that harmful sexual behaviour was outside of the scope of this needs assessment and is not included in the Crime Survey for England and Wales. As such the Project Team has not attempted to estimate the prevalence of harmful sexual behaviour in Nottinghamshire.
- 5.17 The Project Team understands that both Nottinghamshire County and Nottingham City Safeguarding Children Partnerships have processes in place to ensure that the needs of all children who come to the attention of the police, the youth offending service or children's services for harmful sexual behaviour. Within Nottingham City this is through Assessment of Sexual Harm Arrangements (ASHA) meetings, and within Nottinghamshire, this is through the HSB Panel process. The purpose of these meetings is to:
- Bring together the practitioners currently involved with the young person;
 - Discuss the outcomes of assessments, with a view to agreeing on the level and type of risk which s/he may pose in different settings (e.g. at home, at school, in public places);
 - Consider the holistic assessment, agree on how his/her needs are to be met in a service plan for him/her and the family and establish whether there is agreement to the service plan;
 - Specific input within the service plan to help reduce the risk of a pattern of sexually abusive behaviour developing;
 - Recommend actions to manage the risk of Sexual Abuse, bearing in mind any criminal justice action being taken.
- 5.18 The Project Team was informed that in most circumstances a plan will be agreed to be managed and reviewed under child in need procedures. Where a level of risk is identified it may be appropriate for a risk Strategy Meeting to be convened or the child to be considered under the Multi Agency Public Protection Arrangements (MAPPA) if the child is convicted. A child assessed as having sexually abused others should be the subject

of a Child Protection Conference if he or she is also considered personally to be at risk of continuing Significant Harm.

5.19 The IICSA report into Nottinghamshire Councils made specific recommendations for Nottingham City Council and Nottinghamshire Country Council about harmful sexual behaviour and the Project Team understands that both local authorities are developing action plans to meet the recommendations made in the IICSA report.²⁰

Understanding Prevalence Across Protected Characteristics

5.20 Presented below is a breakdown of the prevalence of sexual violence experience against protected characteristics from the CSEW.

Age and Gender

5.21 The CSEW modules show the percentage of adult men and women broken down into age groups who have experienced any sexual assault since the age of 16, in the past year and during childhood.

Figure 11 Prevalence Rates based on Age and Gender for Adults' Experience of Sexual Violence

Gender		Men		Since the age of 16	Women	
		Past Year ²¹	In Childhood ²²		Past Year	In Childhood
All adults	Since the age of 16	0.8	2.6	24.3	3.1	6.6
16-19		3.0	0.9		8.8	5.1

²⁰ <https://www.iicsa.org.uk/news/inquiry-publishes-report-nottinghamshire-councils>

²¹ CSEW Table 10: Prevalence of sexual assault in the last year among adults aged 16 to 59, by personal characteristics and sex, year ending March 2017 CSEW
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwalesappendixables>

²² CSEW Table A4b: Proportion of adults who experienced sexual assault during childhood by type of sexual assault
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/abuseduringchildhoodappendixable>

20-24		1.7			7.2	
25-34		1.1	1.7		3.2	8.1
35-44		0.4	2.8		1.7	11.7
45-54		0.2	4.0		1.3	14.2
55-59		0.1	4.1		1.2	14.7

Ethnicity

5.22 CSEW data consistently shows differences in the percentage of people reporting experiences of recent and non-recent sexual violence based on their ethnicity. While 0.9% of white British men and 3.4% of white British women reported experiencing sexual assault, those from mixed/multiple ethnic backgrounds the percentage increases to 2.98% for men and 4.2% for women

5.23 For those reporting assault in childhood this estimates nearly double for white people with 6.9% experiencing any sexual assault in childhood. For those from a mixed or multiple ethnic background this estimate increases to 18.7%.²³

Figure 12 Prevalence Rates based on Ethnicity for Adults' Experience of Sexual Violence

Experience of Any Sexual Assault	CSA ²⁴	Assault in the last year Adults ²⁵	
		Men	Women
White British	7.1	0.9	0.0
White Irish	9.6	1.0	3.2
Any other white background	4.6	0.7	3.1
Black Caribbean		0.4	6.2
Black African		0.4	3.2
Any other Black background		0.0	5.6

To note the CSEW does not include a breakdown of ethnicity within the gender categories.

²⁴ CSEW Table A4b: Proportion of adults who experienced sexual assault during childhood by type of sexual assault and personal characteristics, year ending March 2016 CSEW

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/abuseduringchildhoodappendixtable>

²⁵ CSEW Table 7: Percentage of adults aged 16 to 591 who were victims of sexual assault (including attempts) in the last year, by personal characteristics and sex, year ending March 2016 to year ending March 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwalesappendixtables>

White & Black Caribbean	11	0.0	3.6
White & Black African	-	0.0	-
White & Asian	6.2	0.0	9.3
Asian - Indian	3.5	0.4	3.0
Asian - Pakistani	2.2	0.2	2.7
Asian - Bangladeshi	1.8	0.0	0.0
Any other Asian background	2.2	0.0	3.1
Any other mixed	3.2	2.8	4.2
Chinese	2.2	2.1	1.7
Any other ethnic group	6.6	1.3	5.3
Other ethnic group - Arab	3.2	1.5	4.0
Not stated	-	-	

Religion

5.24 The CSEW does not provide a breakdown of the experience of sexual violence in relation to the religion of the victim/survivor. However, the Project Team has included a breakdown of the local population by religion taken from the Census.

Figure 13 Population of Nottingham City /Nottingham by Religion from the Census 2011 ²⁶

Percentage of the population	No Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Any Other Religion
Nottingham City	42.57%	43.23%	0.20%	1.38%	0.58%	10.18%	0.17%	1.69%
Nottinghamshire County	50.25%	47.73%	0.00%	0.18%	0.00%	1.16%	0.00%	0.68%

Disability

5.25 The CSEW does not include questions around the prevalence for those with disabilities. However a World Health Organisation review ²⁷ showed

²⁶ KS209EW Religion, local authorities in England and Wales

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/2011censuskeystatisticsforlocalauthoritiesinenglandandwales>

²⁷ <https://www.who.int/disabilities/violence/en/>

that children with disabilities were 2.9 times more likely than their non-disabled peers to be victims of sexual violence, and those with intellectual impairments are most at risk.

5.26 The proportion of people experiencing long-term health problems or disability from the Census 2011 are shown below. It should be noted that disability will likely change over a lifetime with older people presenting with more disabilities and long term health conditions.

Figure 14 Percentage of the Nottinghamshire population reporting experience of disability ²⁸

Percentage of population experiencing long-term health problem or disability	Day-to-day activities limited a lot	Day-to-day activities limited a little	Day-to-day activities not limited
Nottinghamshire County	9.7%	10.6%	79.7%
Nottingham City	9.1%	9.1%	81.9%

Sexuality

5.27 The CSEW does not include questions on the sexuality of victims/survivors and therefore prevalence data around sexuality is not provided. The following data about sexuality is based on the 3-year annual population survey.²⁹ The Nottinghamshire polling numbers were too low around this area to allow accurate reporting therefore the East Midlands population percentage is shown for reference.

²⁸ Table QS303EW 2011 Census: Long-term health problem or disability, local authorities in England and Wales
<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/2011censuskeystatisticsandquickstatisticsforlocalauthoritiesintheunitedkingdompart1>

²⁹ Annual Population Survey sexual identity estimates for UK by sex and age group,
<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/articles/subnationalsexualidentityestimates/uk2013to2015>

Figure 15 3-Year Annual Population Survey data extrapolated to show population of Nottinghamshire (including City) by sexual identity

Percentage of the population	Heterosexual or straight	Gay or lesbian	Bisexual	Other	Don't know or refuse
Nottinghamshire (including City)	97%	1.4%	0.4%	0.4%	1.0%
East Midlands	93.8%	1.1%	0.6%	0.3%	0.1%

Part 3. Prevalence and Demand

Chapter 6: Recorded Sexual Offence Data

Police Recorded Sexual Offences

- 6.1 In the last decade, the number of recorded cases of rape has increased by 348% and for other sexual offences 223%.³⁰ It is thought that improvements in police recording practices and an increased willingness of victims to come forward and report sexual offences to the police have contributed to increases over recent years.
- 6.2 Overall there was an increase of 7% in the number of sexual offences (9% for rape offences and 6% of other sexual offences) recorded by the police in the year ending March 2019 compared with the previous year. The increased reporting for 2019 represents a smaller increase than in recent years, for example in 2018, the rate of increase was 24%. The increase in sexual offences against children contributed to around one-fifth (20%) of the total increase in the number of sexual offences recorded by the police.
- 6.3 It is important to note that sexual offences recorded by the police are not a reliable measure of levels or trends in this type of crime. Despite the huge increase, it is widely accepted that the majority of victims/survivors do not report their experiences to the police. Recent Home Office research³¹ which compared prevalence statistics from the CSEW and the Police Recorded Offences, suggests that a multiplier of 3.4 should be applied to police recorded statistics for rape offences and 16.5 for other sexual offences in order to provide accurate estimates of individuals

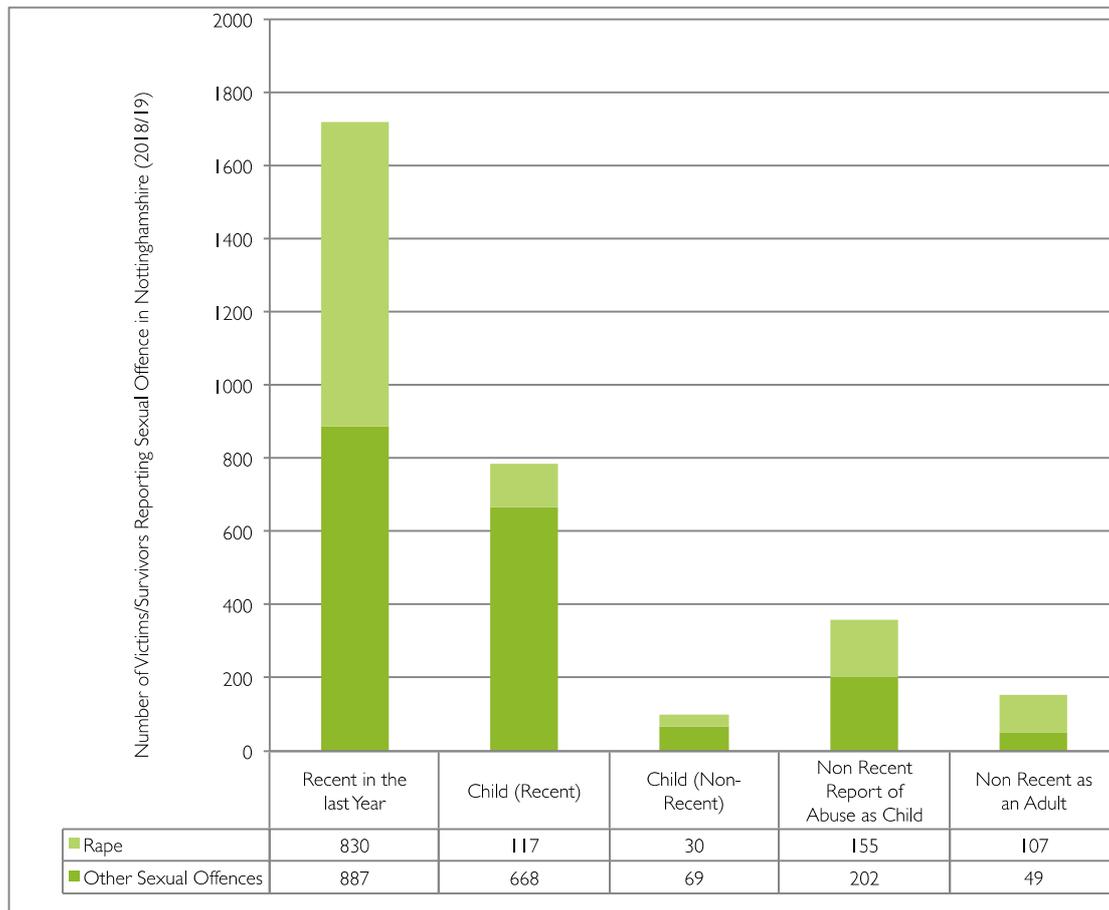
³⁰ Crime in England and Wales: year ending March 2019 Statistical Bulletin
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2019>

³¹ Home Office Research into the Economic and Social Costs of Crime (1999)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732110/the-economic-and-social-costs-of-crime-horr99.pdf

experience of these offences. The recommendation is to apply Estimates from the Crime Survey of England and Wales.

- 6.4 However, police recorded figures are important, as reporting to the police will often form a key referral point into the pathways of support available for victims/survivors of sexual violence and abuse.

Figure 16 Number of Police Reports of Sexual Offences Adults and Children in 2018/19 categorised by Recent and Non-Recent and Offence Type (n= 3128³²) recorded by Nottinghamshire Police Force Area



In addition to the figures shown above recent offences 5 adults reporting rape occurring as a child and 9 other sexual offences but had become adults in the time take to report.

6.5 Previously local data reported in relation to police recorded crime has not distinguished between adults reporting abuse in childhood and those reporting a non-recent (more than a year ago) offence. A further breakdown by City/County is shown in Appendix E.

6.6 The majority of children and adults reporting rape or other sexual assault are reporting a recent experience. However, 17% of those reporting other

³² 147 cases were excluded as either the age at reporting or age at offence was not recorded/reported.

assault and 14% of those reporting rape are reporting experience as a child, which may have occurred decades ago.

- 6.7 The majority of offences against children appear to be reported within a year, however, data shows that a significant proportion of these victims/survivors will present more than a year following the experience.

Outcomes from Police Reporting

- 6.8 Every year, the Rape Monitoring Group (RMG) publishes data from the 44 force areas in England and Wales. This data shows how cases of rape are dealt with at all stages of the criminal justice process including Police and CPS Outcomes and are intended to promote improvements in outcomes for these offences.

Police Decisions to Charge

- 6.9 Nottinghamshire Police took the decision to charge in 5.50% of offences reported in 2017/19. It is important to note that a number of factors influence the charging decision, including evidential difficulties which can include the victim being unable/unwilling to support the action. Nationally the figure is 4.48%. The national trend is for a reduction in the number of cases proceeding to a charge.

Figure 17 Recorded outcomes for Rape Offences in Nottinghamshire Police Force Area³³

	2017/18	2016/17	2015/16
Reported Offences	1309	867	788
Charges	72	44	46
% Charges	5.50%	5.07%	5.84%

³³ <https://www.justiceinspectors.gov.uk/hmicfrs/our-work/article/rape-monitoring-group-digests/#data>

CPS Referral and Decisions to Charge

6.10 Of the 127 referrals to the CPS made by by Nottinghamshire Police, 69.3% were referred back with a decision made by CPS not to charge. Nationally this figure was even higher (at nearly 88% of those referred returning with the decision by CPS not to charge).

Figure 18 Number of referral and decisions to charge by CPS for Nottinghamshire Police Force Area 2017/18 ³⁴

FY	2017-18			2016/17			2015/16		
Type	Referral to CPS	Decision not to charge	% Decision not to charge	Referral to CPS	Decision not to charge	% Decision not to charge	Referral to CPS	Decision not to charge	% Decision not to charge
	127	39	69.29%	136	50	63.24%	119	55	46.21%

6.11 103 rape prosecutions were brought by the CPS in Nottinghamshire for the 2017/18 period, 75 of which resulted in a successful prosecution, and 38 resulted in an unsuccessful prosecution. That is, 34% of all prosecutions for rape brought by the CPS were unsuccessful in Nottinghamshire. Nationally, 41.6% of cases were unsuccessful in 2017/18.

Figure 19 Number of Successful and Unsuccessful Rape Prosecutions by CPS for Nottinghamshire Police Force Area ³⁵

Financial Year	2017-18			2016/17			2015/16		
Type	Successful	Unsuccessful	% Unsuccessful Convictions	Successful convictions	Unsuccessful convictions	% Unsuccessful Convictions	Successful convictions	Unsuccessful convictions	% Unsuccessful Convictions
	75	38	34%	54	32	37%	32	17	25%

³⁴ <https://www.justiceinspectorates.gov.uk/hmicfrs/our-work/article/rape-monitoring-group-digests/#data>

³⁵ <https://www.justiceinspectorates.gov.uk/hmicfrs/our-work/article/rape-monitoring-group-digests/#data>

- 6.11 The decreasing prosecution rates and number of unsuccessful outcomes for rape has sparked a national debate, with wide media coverage, about the role of the criminal justice system in relation to sexual offences. The Home Office is currently conducting an end-to-end review of rape cases, which will look into what happens at each stage of the criminal justice process, including actions taken by individual agencies, in relation to adult rape cases. The findings from this review are expected in 2020.

Local Authority Data

Children at risk

- 6.12 In all cases of child sexual abuse, whether it a suspicion, concern or following a disclosure of sexual abuse, the Police and/or Children's Services must be informed. This is clearly laid out in Working Together to Safeguard Children 2020. Police and Children's Services must then work in partnership to determine how to respond to the referral. Strategy discussions/meetings involving key professionals are convened in order to determine the best approach to be taken. As a result of this process, and the Safeguarding procedures, Police and/or Children's Services should be informed of every case of child sexual abuse. Therefore, Local Authority data should mirror that of the police data.
- 6.13 For children the initial identification of concern/need for support is most likely to come via safeguarding referrals to social care. The Children in Need census is a child level data collection, which records individual assessment information and child characteristics for each child who has been referred to children's social care services. It is submitted by local authorities on an annual basis. The data below is presented for 2017/18 as the most recent data will have been submitted in July 2019 and is subject to cleaning and review.
- 6.14 Within this definition sexual abuse involves forcing or enticing a child to take part in sexual activities, including prostitution, activities may involve physical contact, including non-penetrative and penetrative acts or non-penetrative acts.

- 6.15 They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).
- 6.16 The data provides the initial category of abuse as well as the latest category of abuse recorded in Child Protection Plans. For 43 (5.6% of the total cases) in Nottingham City and 40 (5.3% of total cases) in Nottinghamshire sexual abuse was recorded as the initial category. Following assessment this number drops to 23 (3.1% of total cases) in Nottingham) and 4.9% of cases in Nottinghamshire. It is not possible to identify what causes this reduction, ie whether there is a re-categorisation or the identification of sexual abuse cannot be confirmed
- 6.17 It is important to note that the Project Team is aware that in many local authorities where there is sexual abuse identified it may also be recorded as physical abuse. It is not possible to identify whether this is the case in Nottinghamshire without a case-by-case review.

Figure 20 Local Authority Data 2017/18 from NSPCC Data Set on Child Protection Plans³⁶

Local authority Number of child protection plans starting during the year		Initial category of abuse					Latest category of abuse				
		Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple ⁴	Neglect	Physical Abuse	Sexual Abuse	Emotional Abuse	Multiple ⁴
City	748	305	177	43	223	0	303	149	23	273	0
%		40.8	23.7	5.7	29.8	0.0	40.5	19.9	3.1	36.5	0.0
County	921	444	42	40	213	182	418	37	37	241	188
%		59.4	5.6	5.3	28.5	24.3	55.9	4.9	4.9	32.1	25.1

- 6.18 The data above also provide the factors identified at the end of assessment which include sexual abuse for 443 (6.4% of those assessed)

³⁶Table C3: Number of episodes¹ with assessment factor information, in the year ending 31 March 2018
 Characteristics of the Children in Need Dataset <https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018>

in Nottingham and 504 (9.4%) in Nottinghamshire. It should be noted that in this assessment a number of factors can be identified for each child. In addition, for 17 children (0.2% of those assessed in Nottinghamshire) FGM was identified as a factor.

Figure 21 Characteristics of Children identified in need in Nottinghamshire Factors Identified at Assessment ³⁷

Local authority Number of episodes with assessment factor information/ % of assessments with factor		Factors Identified at end of assessment							
		Self-harm	Neglect	Emotional abuse	Physical abuse	Sexual abuse	FGM	Abuse linked to faith/belief	Other factors
England	482,750	21,440	88,660	104,760	71,630	30,840	94	1,630	93,330
%		4.4	18.4	21.7	14.8	6.4	0.2	0.3	19.3
City	4,691	393	843	1,368	901	443	17	68	961
%		4.4	18.4	21.7	14.8	6.4	0.2	0.3	19.3
County	7,749	282	1,090	1,016	1,070	503	x	9	564
%		8.4	18.0	29.2	19.2	9.4	0.4	1.4	20.5

Adults at risk

6.19 Adults at risk must also be safeguarded against sexual violence by social care and police, however, some adults at risk may require the support of services aimed at children or young people, depending on their consent and capacity needs.

6.20 Nottingham City have identified within their social care team the following number of safeguarding referrals in 2018/19 where the nature of the abuse is sexual, of which 91 lead to a Section 42 (Safeguarding) Enquiry though the outcome of these is not reported. To note: this provides the overall numbers of those being referred to services. We are aware a number of services are currently running waiting lists and

³⁷Table D4: Number of children who were the subject of a child protection plan at 31 March 2018, by local authority, initial1 and latest category2 of abuse Characteristics of the Children in Need Dataset
<https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2017-to-2018>

therefore not all of these will have accessed a service, however, it provides a general estimate of the demand on services.

6.21 Nottinghamshire County Council were unable to provide the Project Team with comparable data as it is not possible to extract from systems.

6.22 However national reporting of this data for 2017/18 (under the Safeguarding Adults Data Set) shows the number of cases for each local authority which concluded in a Section 42 enquiry and identified risks around sexual abuse or exploitation.

Figure 22 Categories of concluded Section 42 enquiries identified risks around sexual abuse or exploitation in Nottinghamshire 2017/18³⁸

No of concluded Section 42 enquiries by risk	Physical Abuse	Sexual Abuse	Psychological Abuse	Financial or Material Abuse	Discriminatory Abuse	Organisational Abuse	Neglect and Acts of Omission	Domestic Abuse	Sexual Exploitation	Modern Slavery	Self Neglect
City	705	130	420	395	10	410	1235	85	*	10	60
County	305	95	210	315	5	45	665	60	5	*	20

³⁸ Table 2: Count of concluded Section 42 enquiries¹ by type of risk² <https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2017-18-england>

Part 3. Prevalence and Demand

Chapter 7: Demand for Local Services

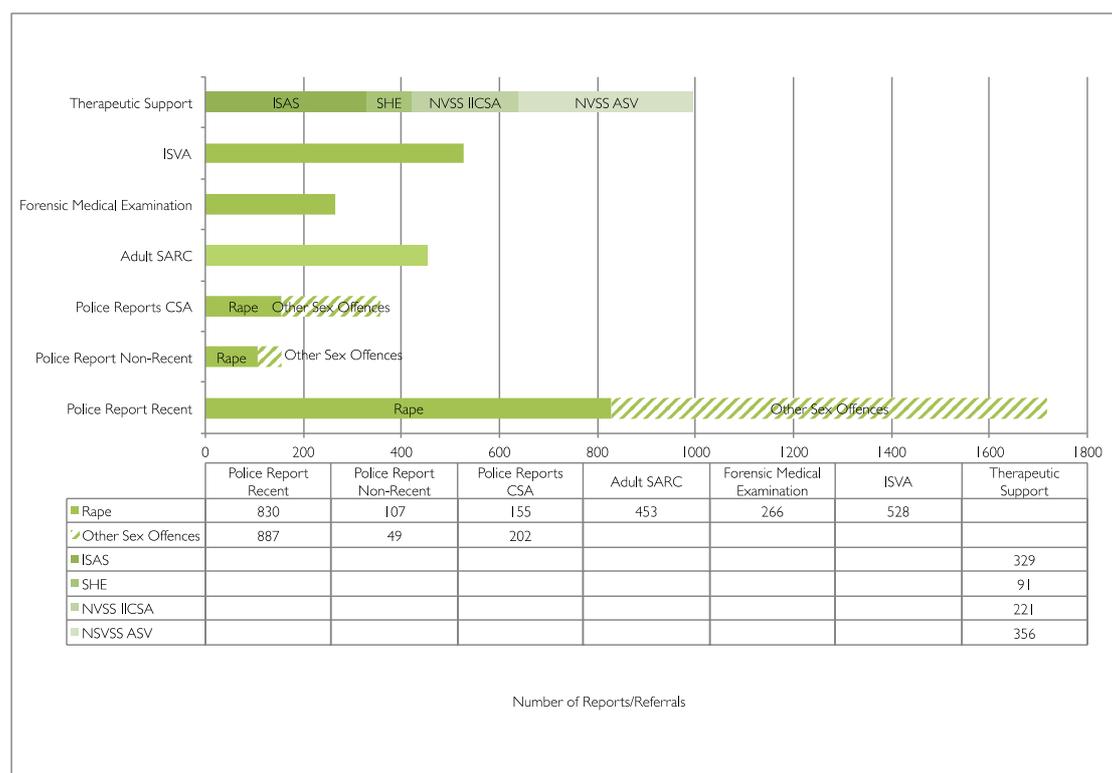
- 7.1 In attempting to ascertain the demand for services, the Project Team requested data from the commissioned specialist sexual violence support services. It is important to note that prior to April 2019 these commissioned specialist sexual violence support services did not collect a common data set, or conduct comparable needs assessments to demonstrate the need of those accessing their services. Therefore it has not been possible for the project Team to provide any meaningful comparable analysis of the access and demands on these services. However, the OPCC has confirmed the Ministry of Justice's final victims outcomes framework data set is now collected as part of their commissioned contracts moving forward, however this may not be the case for other commissioners/block contracts.
- 7.2 While it is possible from the data collected to show the number of victims/survivors who accessed these services during a specified period, due to the nature of the support pathways, individual victims/survivors of sexual violence and abuse may be accessing a number of different services from different providers to meet their needs. The data below is not able to identify double-counting, for example where a single victim/survivor has accessed the SARC, ISVA service and therapeutic service this would not be identified by the data returned.

Adult Services

- 7.3 Figure 23 shows the number of referrals to these services in 2018/19. The Project Team has included in this table the number of victims/survivors of sexual violence and abuse who reported to the police, which represents the largest cohort of victims/survivors of sexual violence and abuse. A further breakdown by City/County is shown in Appendix E.

7.4 The data shows that not all victims/survivors who report to the police are accessing specialist sexual violence support services. This may be due to a number of factors, which is mostly impossible to determine but may include lack of signposting/onward referral to specialist sexual violence support services, or that the victim/survivor is not ready or willing to access support services. It is important to note that survivors may however, be accessing mainstream or third sector services for purposes other than sexual violence.

Figure 23 Graph to show the number of Adult Victims/Survivors Reporting to the Police and the demand on services providing support by number of victims/survivors accessing support in 2018/19



Demand on the Adult SARC (Topaz Centre)

7.5 Since 2018, the SARC service, known as the Topaz Centre, has been provided by Mountain HealthCare Ltd. A SARC helpline provided by Crisis

Workers operates 24 hours and provide telephone, email advice and onward referral both to victims/survivors and to professionals including the police.

- 7.6 The Topaz Centre provides:
- Forensic Medical Examination
 - Post Exposure Prophylaxis (PEP)
 - Emergency Contraception
 - Onward referral to
 - Sexual Health services
 - ISVA services
 - Therapeutic Support
 - Drug and Alcohol Services
 - Homeless and Housing Organisations
 - Other support agencies
- 7.7 While the majority of referrals to the Topaz Centre are from the police (60%), a significant proportion comes as self-referrals (30%) and agency referrals (10%). The SARC also supports anonymous reporting including evidence gathering.
- 7.8 During 2018/19, 286 clients were seen at the SARC, 266 of which received forensic medical examinations. 106 victims received telephone support and onward referral to other services only. An additional 61 cancelled their appointment or withdrew the report prior to attending.
- 7.9 For all victims/survivors a detailed risk and needs assessment is collated by the Topaz Centre, which also monitors a range of vulnerability factors including domestic violence, history of mental health issues, signs of self harm, learning disability factors, physical disability, sex worker and substance misuse. After 6 weeks, crisis workers complete a further follow up call to identify whether there are any further needs.
- 7.10 While the National SARC Specification includes the provision of up to 10 therapeutic support sessions, these are not included as part of the local commissioning specification for the Topaz Centre.

Demand on the Independent Sexual Violence Adviser (ISVA) Service

- 7.11 Notts SVSS was commissioned to provide a county-wide ISVA service from 2018. During 2018/19, 578 victims/survivors were referred to the ISVA service, of these 548 received support. The remaining survivors either declined support or were unable to be contacted by the service.
- 7.12 Referrals to the ISVA service come from a range of sources, although the majority in 2018/19 were from the SARC (55%) and police including forces outside of Nottinghamshire (13%). Other referrals make up 10.4% of the referrals to the ISVA service include NSVSS services (such as the helpline), other specialist therapeutic support and other third sector services. 5% of ISVA service referrals are self-referrals.
- 7.13 All referrals to the ISVA service are risk and needs assessed across the domains of the Safety and Support (SAS) Assessment³⁹, a bespoke assessment tool for ISVAs. The data from the ISVA service for 2018/19 shows the majority of victims/survivors of sexual violence and abuse who accessed the ISVA service had risks and needs in relation to:
- Mental Health and Psychological Wellbeing (13.7%)
 - Criminal Justice System (12.1%)
 - Coping Mechanisms & Social and Cultural Support (11.9%)
 - Harm from Other (10.6%)
 - Health and Medical Needs (10.1%)

Figure 24 Support needs identified for those accessing the ISVA Service

Identified Needs	% of Victims/Survivors with Identified Needs in these areas
Mental Health and Psychological Wellbeing	13.7%
Criminal Justice	12.1%
Coping mechanisms, Social and Cultural support	11.9%
Harm from Others	10.6%

³⁹ <https://limeculture.co.uk/wp-content/uploads/2017/11/Safety-and-Support-Assessment-SAS-Toolkit.pdf>

Health and Medical	10.1%
Employment and Education	9.8%
Finance	7.8%
Accommodation and Housing	6.9%
Alcohol and Drug Use	4.6%
Safeguarding	3.6%
Personal and Individual Requirements	3.3%
Risk to Professionals and Services	0.7%
Immigration and Residence	0.5%

7.14 Data collected by the ISVA service during 2018/19 show the ISVA service clients report the following improvement following engagement with ISVA services

- Improved physical health
- Improved mental health
- Feeling safer
- Feeling more stable in home environment
- Improved relationships with family and friends
- Improved social relationships
- Reduced dependency on drugs and alcohol
- Improved financial situation

Survivor Support Service

7.15 More recently the PCC and Local Authorities have jointly commissioned a Survivors Support Service, provided by Notts SVSS, which has been operating since July 2017. This provides an ISVA-like service offering support and advocacy specifically for adult victims/survivors of child sexual abuse which took place whilst they were in the care of authorities.

7.16 The number of individual referrals from service commencement to the end of March 2019 is 105. The number of individual referrals from 1st March 2019 to the end Sept 2019 is 28. Out of all the 133 referrals from service commencement, the number of open cases at the end of Sept 2019 is 62.

7.17 The Project Team was informed that the number of the self-referrals are likely to have been generated through engagement with the Sexual Violence Engagement Manager (employed by PCC) and news of the service spreading by word of mouth amongst victims/survivors of sexual violence and abuse.

7.18 The support needs of new clients of those accessing the Survivor Support Service identified through the use of the Safety and Support (SAS) Assessment domains include mental health and wellbeing (12.8%) and coping mechanism and social support (12.8%), Health and Medical Needs (11.4%).

Figure 25 Support needs identified for those accessing the Survivor Support Services

Identified Needs	% of Victims/Survivors with Identified Needs in these areas
Mental Health and Psychological Wellbeing	12.80%
Coping mechanisms, social and cultural support	12.80%
Health and Medical	11.40%
Personal and Individual Requirements	7.60%
Finance	7.60%
Employment and Education	7.10%
Criminal Justice	6.60%
Harm from Others	6.20%
Accommodation and Housing	5.70%
Alcohol and Drug Use	4.30%
Risk to Professionals and Services	2.40%
Immigration and Residence	1.90%
Safeguarding	0.50%

Demand on Therapeutic Support Services

SHE-UK

7.19 Based in Mansfield, SHE-UK deliver the commissioned therapeutic support from locations in the north of the County. In 2018/19 SHE-UK

was funded by Ministry of Justice and received a small grant from the PCC and County Council. In total, during 2018/19 the service was referred and accepted 41 of clients in therapeutic services which including:

- 1:1 counselling,
- (female-only) day lounges (staffed by key workers, who provide goal setting and developing healthy living strategies) and
- creative workshops.

7.20 It is important to recognise that SHE-UK was not a locally commissioned service during 2018/19 and only in receipt of a small grant. Therefore, referral data was limited as reporting was not a monitoring requirement of the commissioners. No waiting list for therapeutic support at SHE-UK is reported.

ISAS

7.21 Based in Newark, ISAS provide services across the county of Nottinghamshire excluding the city (although support is provided to county survivors from a city base). This organisation provides volunteer counsellors based support to male and female clients and includes:

- up to 20 sessions of counselling/therapy,
- creative arts workshops and groups.

7.22 During 2018/19 ISAS received 329 new referrals into the service self referral make up the highest proportion (38.30%), GP (17.33%) and IAPT services (nearly 20%) and mental health services (2.4%). The majority of victims/survivors were seeking support around their experience of Child Sexual Abuse (33.1%), Mental Health (21%) and Children and Family Relationships (17.3%) and Substance Misuse (11%). Needs are identified and outcomes assessed based around Health, Safety and Stability, Resilience and Autonomy. The Project Team is aware that ISAS are currently operating a waiting list of up to 4 months.

Figure 26 Support needs identified for those accessing ISAS therapeutic services

Identified Needs	% of Victims/Survivors with Identified Needs in these areas
Child Sexual abuse	33.1%

Mental Health	21.0%
Children and Family Relationships	17.3%
Substance Misuse	11.0%
Offending	3.3%
Education/Training/Employment	3.2%
Physical Health	3.1%
Survivor of Multiple Perpetrators	2.1%
Housing	1.5%
Sexual Health	1.0%
Post Separation Abuse	0.8%
Contact Arrangements	0.8%
Finance and Debt	0.7%
Referral to WAIS	0.5%
Sexual Exploitation	0.4%
Adolescent to Parent Violence	0.1%
Stalking	0.1%
Gang Related Violence	0.1%

Nottinghamshire SVSS (NSVSS)

7.23 NSVSS provides a range of counselling support including:

- 1:1 counselling
- group therapy
- support via email, telephone or online including on line self-help programmes

7.24 NSVSS clients can be male or female and either survivors of recent or non-recent abuse. NSVSS provide 20 sessions of therapy, reviewed at 10 sessions and then extended beyond 20 only where required. They can re-refer into therapy after 12 months.

7.25 During 2018/19, NSVSS received 577 referrals across the range of counselling services via a range of sources including the SARC (11.2%), self-referrals (57%), other voluntary sector organisations (10.8%) and other services amount to 21% of referrals .

7.26 The needs of those referred to the service in 2018/19 are identified below. The majority were seeking support around Children and Family Relationships (20.13%), Child Sexual Abuse (16.1%), Mental Health (15.1%)

and Education Training and Employment (15%) and Substance Misuse (11.7%). Outcomes assessed around Health, Safety and Stability, Resilience and Autonomy.

7.27 At present, Notts SVSSS report the service has around a one year awaiting list for counselling. Survivors on the waiting list have access to the helpline and are contacted regularly to ensure that their circumstances have not worsened whilst they are on the list.

Figure 27 Support Needs identified for those accessing the NSVSS therapeutic Services

Identified Needs	% of Victims/Survivors with Identified Needs in these areas
Children and Family Relationships	20.1%
Child Sexual abuse	16.1%
Mental Health	15.1%
Education/Training/Employment	15.0%
Substance Misuse	11.7%
Survivor of Multiple Perpetrators	6.9%
Housing	4.1%
Physical Health	4.0%
Sexual Health	3.4%
Sexual Exploitation	1.1%
Contact Arrangements	0.5%
No Recourse to Public Funds	0.4%
Stalking	0.4%
Finance and Debt	0.4%
Gang Related Violence	0.2%
Referral to the SARC	0.2%
Referral to WAIS	0.2%
Human Trafficking	0.1%
Forced Marriage	0.1%
Requiring Interpreter	0.1%

Children & Young People Services

7.28 From the data below it seems a high proportion, though not all, of those reporting child sexual offences are accessing CHISVA and therapeutic services. However, the data does not show the wait experienced by individuals for support.

Paediatric SARC - East Midland's Children and Young People's Sexual Assault Service

- 7.29 During 2018/19, 123 referrals were made to the East Midland's Children and Young People's Sexual Assault Service (Paediatric SARC). 64 of those required a forensic medical examination. 59 others received a physical examination by a paediatrician to identify areas of injury. In addition to examinations, the paediatric SARC assessed children and young people needs for pregnancy, STI, self harm, child sexual exploitation, Female Genital Mutilation (FGM), domestic abuse, with referrals made onward for sexual health services and psychological (therapeutic support) and CHISVA services.
- 7.30 The majority of referrals to the paediatric SARC came from the police and social care, however, there were a few are self-referrals from young people between 16-17 seeking advice and support.
- 7.31 The paediatric SARC will refer children and young people on to a range of services, including therapeutic support CHISVA service, sexual health and safeguarding⁴⁰.
- 7.32 Crisis Workers will check and follow up with children and families and services that referrals have been received. Reports are sent to the GP of the child/young person, public health nursing team, Children's Social Care, Police and any other professional known to be providing care to the child.

⁴⁰ Project Team discussions with the SARC suggest these are made where the police have not yet completed a safeguarding referral for the presenting victim/survivors, rather than identifying additional safeguarding needs

Figure 28. Graph to show the number of Children and Young People reporting sexual offences to the police in 2018/19 and the overall numbers of Children and Young People accessing support services in Nottinghamshire Police Force Area



Children’s and Young People’s Independent Sexual Violence Advisor (CHISVA) service

7.33 The Children’s and Young Peoples Sexual Violence Advisor (CHISVA) service was commissioned in 2018 for children and young people who have experienced sexual violence and abuse (either recent or non recent). The service is a county-wide service for anyone under the age of 18. The CHISVA service is provided by Imara.

7.34 During 2018/2019, the CHISVA service received 136 referrals via the commissioned Paediatric SARC pathway. Support was provided to 173 cases as this includes support for siblings/parents For 9 cases, they provided support for victims/survivors originally referred inappropriately to the adult ISVA service.

7.35 CHISVA service clients are individually assessed using the Safety and Support (SAS) Assessment, a bespoke assessment tool for ISVAs. 23.2% of their clients had needs around the criminal justice process, mental health and psychological wellbeing (17.1%), coping (including support for their family) and education.

Figure 29 Support Needs identified for those accessing the CHISVA Service for Nottinghamshire Police Force Area

Identified Needs	% of Victims/Survivors with Identified Needs in these areas
Criminal Justice	23.2%
Mental Health and Psychological Wellbeing	17.1%
Coping mechanisms, social and cultural support	14.6%
Employment and Education	11.0%
Personal and Individual Requirements	9.8%
Harm from Others	6.1%
Health and Medical	4.9%
Accommodation and Housing	4.9%
Safeguarding	3.7%
Finance	3.7%
Professional Judgement	1.2%

7.36 The CHISVA service will refer to therapeutic services, safeguarding, education, child health and safeguarding services as well as providing support around employment and education. It should be noted that Imara also provide a child therapy service which is not commissioned as part of the SAAS pathway. Referrals to the therapy service are not reported to commissioners, however, internal data suggests more than 50% of CHISVA clients are referred to therapeutic support within Imara.

Therapeutic Services for Children

7.37 At present the paediatric SARC specification includes up to 10 therapeutic support sessions. For Nottingham City, Imara and NSVSS are sub-contracted to provide these sessions and are currently able to do so without a wait. In 2018/19 Imara received 94 referrals. However child and young people in Nottinghamshire County are referred to an existing

service (Safe Time) commissioned by the County Council which reports waiting lists of up to a year for accessing to counselling. Safe Time report that 50% of its 123 referrals in 2018/19 came from the paediatric SARC.

- 7.38 It is important to note that the contracts with Notts SVSS, ISAS and SHE-UK include provision for victims/survivor of sexual violence who are 13years old. From the data provided by these services, for the period 2018/19, Notts SVSS provided support to 161 children between the ages of 13-17 years old and ISAS provided support to 3 children between the ages of 13-17 years old. No breakdown of therapeutic provision for children between the ages of 13-17 was available from SHE-UK for this period, due to previous monitoring arrangements for grant funding (see above).

Demand on Mainstream and Third Sector services

NHS Mental Health Services

- 7.39 At present there is no indicator for sexual violence within the NHS mental health service datasets and therefore the Project Team is unable to quantify the number of victims/survivors of sexual violence and abuse have been supported by NHS mental health services. However, it is important to note that research on the mental health of those accessing Sexual Assault Referral Centres (SARC) suggests that up to 70% of those accessing SARC services⁴¹ will previously have been experiencing mental health conditions.

Improving Access to Psychological Therapies (IAPT) services

- 7.40 At present there is no indicator for sexual violence within the IAPT dataset and the Project Team is therefore unable to quantify the number of victims/survivors of sexual violence that have been supported by IAPT services.

⁴¹ C. Brooker, et al. (2019) Journal of Forensic and Legal Medicine 68 (2019) 101862

7.41 However, IAPT providers informed the Project Team that they are able to provide support to people who have experienced sexual violence and indeed have done successfully. The Project Team was informed that experience of sexual violence was not exclusion to receiving services and that support provided by IAPT services was trauma informed. However, the lack of an indicator within the IAPT data set means that the Project Team are unable to clearly identify the level of demand on their services from victims/survivors of sexual violence and abuse. A pilot has recently been developed to identify a pathway for victims/survivors with Insight subcontracting to NSVSS (see chapter 12).

Demand for other services

7.42 As noted previously victims and survivors of sexual violence will access support from a range of other organisations including domestic abuse, housing, drug and alcohol services, sexual health services, GP, Emergency Departments. Anecdotal reports from professionals indicate high numbers of victims/survivors of sexual violence and abuse accessing these services. However, disclosures tend to be recorded within risk and needs assessment or client records, meaning that services are unable to provide quantitative data on the demand for services from victims/survivors of sexual violence.

Offenders

7.43 The Project Team attempted to access data about the number of offenders who may have been victims/survivors of sexual violence and abuse. No data was available from the local Community Rehabilitation Company. For other services, while this may be recorded in assessment or records, it is not routinely recorded as part of a data set that can provide quantitative data to support this needs assessment.

Female Genital Mutilation (FGM)

- 7.44 According to the Strategic Direction for Sexual Assault and Abuse Services ⁴²FGM is a form of child sexual abuse. It is described by the World Health Organisation as ‘a procedure that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non--medical reasons’. It has been detailed as one of the offences covered under the
- 7.45 FGM has no health benefits for women and girls, and instead is believed fulfil certain cultural beliefs and traditions held by some community groups. FGM can cause severe short and long-term health problems and is recognised internationally as being a violation of the human rights of women and girls. Young females from infancy to the age of 15 at the most likely to undergo FGM.
- 7.46 The number of newly identified FGM cases recorded by GP practices, hospitals and healthcare providers in Nottinghamshire fell from 85 in 2016/17 to 70 in 2017/18, with the majority (81%) recorded in the city. The majority were identified via examinations of pregnant women who had undergone the procedure in their home country, either before the age of 15 or between the ages of 1 and 9. Victims were predominantly from Eastern Africa, Northern Africa or Western Africa with a smaller number being identified from Asia.
- 7.47 Nottingham and Nottinghamshire FGM Steering Group is a cross-authority, multi-agency partnership board with the overall aim of preventing babies, infants, children and all females from undergoing this illegal procedure and identifying and supporting women affected by FGM. The Project Team identified the follow areas of unmet need based on discussions with strategic leads and from review of the Joint Strategic Needs Assessment for FGM⁴³ and Annual Report of the Nottingham and Nottinghamshire FGM Steering Group.

⁴² <https://www.england.nhs.uk/wp-content/uploads/2018/04/strategic-direction-sexual-assault-and-abuse-services.pdf>

⁴³ <https://www.nottinghaminsight.org.uk/themes/health-and-wellbeing/joint-strategic-needs-assessment/adults/female-genital-mutilation-2017/>

- 7.48 Nottinghamshire charity, Mojatu Foundation provides support for adult survivors and work with African and Caribbean communities focusing on the empowerment of girls, women and young people through community engagement, media, education and health. This small voluntary organisation supports survivors of FGM. It is not a commissioned service and has small grant funding only.
- 7.49 The Project Team was informed that Nottingham currently has a FGM clinic and a FGM specialist midwife for Adults. The Steering Group has noted the long-term succession arrangements for the continuity of the service, which may result in a service gap for survivors of FGM. This is particularly important as acquiring FGM specialism involves significant on-the-job training with specialists in the field. If this cannot happen before specialist knowledge exits the workforce in Nottingham, acquisition of specialist skills will be difficult for any long term successor. Furthermore, the current FGM clinic is not intended to provide services to non-pregnant women as it is midwifery led. However, the Project Team was informed that women have been seen at the clinic outside of commissioned arrangements, as otherwise these women would not receive a service.
- 7.50 From the 31st October 2015, regulated professionals in health and social care and teachers in England and Wales have a duty to report 'known' cases of FGM in under 18 year olds to the police (see [Mandatory Reporting of FGM](#)). Social Care has a responsibility to safeguard children where there are indicators that FGM may be or has already taken place.
- 7.51 The Police and Crime Needs Assessment reports recorded 13 cases in 2017/18, having fallen from 25 during the previous year. All of these were recorded as safeguarding occurrences as opposed to Home Office notifiable FGM offences. Girls under the age of 16 who are survivors of FGM are referred to the East Midland's Children and Young People's Sexual Assault Service (the Paediatric SARC). However, the Project Team was informed that this is outside of the commissioned role of the SARC.
- 7.52 Access to trauma based mental health support has been cited as difficult for this group. The Project Team is aware that current commissioning of sexual violence and abuse services does not overtly

recognise the needs of FGM survivors. The Project Team is informed that attempts are being made by the Steering Groups to include trauma based mental health services for FGM survivors as part of the reconfiguration of mental health service provision commissioned by the CCGs.

Part 4. Needs of Victims/Survivors of Sexual Violence in Nottinghamshire

Chapter 8: Complexity of Needs

"We all need something that is applicable to where we find ourselves in life. We are all afflicted in different ways. Some of us are on benefits and have addictions. Some of us are high achievers. No one is right or wrong. We have different needs and these need to be addressed."

Survivor, Focus Group Contributor, September 2019

- 8.1 The prevailing theme that emerging from the wide range of interviews and focus groups the Project Team conducted with stakeholders in Nottinghamshire (victims/survivors of sexual violence and professionals who support them) was the recognition of the complexity of need belonging to this client group.
- 8.2 Stakeholders reported that the needs of victims/survivors of sexual violence are frequently '*multiple and on-going*'. The impact of sexual violence can be wide-ranging and devastate the lives of victims/survivors. There is consensus amongst those providing support and the victims/survivors themselves that while some of their needs are a direct consequence of the abuse they have experienced, it is also true that many victims/survivors will have had unmet needs that resulted in them being vulnerable to the victimisation in the first place, and indeed continued re-victimisation.
- 8.3 As such, victims/survivors of sexual violence may present to a variety of services and organisations, and at varying intervals after their experience(s) of sexual violence. Services such as mental health services, drug and alcohol and homeless-housing organisations reported to the Project Team that they are dealing with individuals who are victims/survivors of sexual violence or abuse, although this may not be the presenting issue for their attendance at such services.
- 8.4 Stakeholders reported that amongst the range of services in Nottinghamshire that victim/survivors of sexual violence are likely to be accessing are:
 - Health services (such as GPs, sexual health, mental health and physical health services)

- Social Care (Children Services, Adult services, Early Help Initiatives, Troubled Families Programme etc.)
- Drug and Alcohol services
- Welfare benefits and employment support (such as Job Centres and Futures)
- Domestic Abuse services (such as refuges, IDVA, outreach services)
- Housing and Homeless Support services
- BMER-specific organisations

8.5 Due to the range and complexity of needs frequently experienced by victims/survivors of sexual violence, the commissioned sexual violence support services cannot - and do not- have the ability or expertise to meet the entirety of victims/survivors needs. Stakeholders are clear that where the needs of victims/survivors require more appropriate or specialist support, then such services should also be available to them. For example, where the victim/survivor has a drug and/or alcohol problem, it will be necessary for that need to be met by a drug and alcohol service and not the specialist sexual violence support service. Although in some cases, professionals reported to the Project Team that is a benefit of joint working arrangements between services to provide support especially to avoid any gap in support for victim/survivors.

8.6 It is important to note that victims/survivors may choose not to disclose their experience of sexual violence to other services (often due to reasons including guilt, shame and stigma). Consequently, however, it is unknown exactly which mainstream and third sector services in Nottinghamshire are being utilised by victims/survivors of sexual violence, and to what extent. For example, one victim/survivor told the Project Team: *"I didn't tell my GP about my abuse. I don't want him to know and I don't want it on my records"*.

8.7 It is also important to note that victims/survivors told the Project Team that while some of them choose not to disclose their abuse to services, others willingly share information about their experiences of sexual violence with professionals (often in the hope of getting help or support). For example, the Project Team was told by one survivor: *"I never hid my abuse from professionals. I told them in the hope that somebody would offer me some help. Instead I was told to 'get over it'"*.

8.8 Significantly, during the focus groups and interviews with professionals from drug and alcohol and housing services, it was anecdotally reported to the Project Team that these types of services are supporting 'large numbers' of victims/survivors of sexual violence that professionals estimated to be between 70-80%. However, the

Project Team was unable to corroborate this with any data collected or supplied by services.

Confidence among Professionals to Respond to Victims/Survivors

8.9 In addition to the problems with data collection in mainstream NHS and third sector support organisations (above), stakeholders told the Project Team that there is fear amongst professionals about talking to their service-users where sexual violence is suspected or disclosed. For example, one professional told the Project Team *"We might suspect that somebody is a victim of sexual abuse, but we don't always know how best to ask that question"* Stakeholders expressed concerns about 'opening a can of worms' that they didn't feel equipped to discuss with their clients. Professionals expressed reticence about asking questions about sexual violence. *"No, I don't think I would ask somebody directly [if they had experienced sexual violence]. I wouldn't know how to or what to say and I certainly wouldn't want to get that wrong"*. However, victims and survivors said they would like to see routine enquiry into sexual abuse introduced to all services to underpin and support professionals to identify victims/survivors and understanding their needs

8.10

8.11 A range of professionals from drug and alcohol, housing organisations and other third sector services told the Project Team they did not always feel confident in identifying victims/survivors of sexual violence. These professionals informed the Project Team that further training for professionals would be helpful for them to feel more confident in identifying victim/survivors of sexual violence. *"I'd like to know more about the signs and symptoms of sexual violence - what to look out for"*. One survivor told us *"I thought I was making it so obvious that I had been abused, but nobody seemed to notice...or if they did, they never asked me"*.

8.12 Stakeholders from third sector support organisations told the Project Team that they were aware there is an increased focus on sexual violence both locally and nationally, but that they had not received training around sexual violence. For example, one professionals told the Project Team *"I know that sexual violence is on the agenda across Nottinghamshire but we've never actually received trained on it"*. Stakeholders unanimously agreed that wider training about sexual violence for frontline professionals across mainstream and third sector services would be welcomed.

- 8.13 Stakeholders consistently suggested to the Project Team that there is a need for mainstream NHS and third sector services to take a 'trauma-informed' approach to their work in order to keep victims/survivors from disengaging with their services.
- 8.14 The Project Team is aware that work being done across Nottinghamshire (county) on routine enquiry into adverse childhood experiences. This work is already supporting the up-skilling of professionals in mainstream and third sector services to understand better how to ask appropriate questions about experiences of sexual violence and other adverse childhood experiences.

Awareness of specialist sexual violence support services

- 8.15 Victims/survivors of sexual violence told the Project Team that they felt more should be done to raise awareness of the specialist sexual violence support services available across Nottinghamshire. For example, one victim/survivor informed us that she had *'told many different professionals about the sexual abuse, but not one of them referred me to the right service. I kept being told to tell my GP'*.
- 8.16 Professionals in the NHS and third sector services corroborated this view and said they were not always aware or best placed to know about the entire range of specialist sexual violence support services available to victims/survivors. One professional told the Project Team *"when I was faced for the first time with a service user who disclosed sexual abuse, I had to google to find out whether any services were available. I know about them now, but I didn't before"*.
- 8.17 The Project Team is aware that sexual violence awareness raising has been carried out by specialist sexual violence support services in the past however this is not currently a commissioned activity and is reliant on the providers' capacity to undertake. Furthermore, the Project Team is aware that the adult SARC provides a helpline that can provide information to professionals or victims/survivors. In addition, Juno Women's Aid are commissioned to provide the Domestic and Sexual Violence and Abuse (DSVA) 24 hour helpline for women and can provide referral and signposting. The Project Team was informed that NSVSS also provides information on local services via their counselling helpline.
- 8.18 A range of professionals told the Project Team that formal referral routes between specialist sexual violence supports and mainstream NHS and third

sector support services should be developed to support a seamless pathway for victims/survivors between services.

- 8.19 Victims/survivors reported considerable challenges in navigating the range of different mainstream and third sector services they need to meet their needs. A victim/survivor with multiple and complex needs may require the support of multiple services. Professionals reported to the Project Team that there is a risk of victims/survivors *'bouncing around different services'* and becoming confused or overwhelmed by the number of professionals they may be dealing with at any one time. One victim/survivor told the Project Team *"At one point, I was in contact with so many services, I couldn't remember who was who and it just confused me more. It was too much so I stopped talking to any of them"*.
- 8.20 Victims/survivors also informed the Project Team that they were often asked to repeat sensitive information about their abuse to multiple professionals/services. One victim/survivors said *"I can't count the number of times I have had to replay my abuse to professionals so they can assess me"*.
- 8.21 The Project Team repeatedly heard from survivors that they would prefer not to have to repeat details of their experience and needs when accessing new services. Professionals confirmed this view by suggesting information could be shared between services to avoid the need for the victim/survivor to have to repeat information multiple times. One victim/survivor said *"if the service could be made aware of my abuse before I got there that would be great. I don't know if some kind of card could be used... or something... that alerts them to the fact I am a survivor without me having to tell the details again"*.
- 8.22 Due to the range of needs that victims/survivors often have, stakeholders informed the Project Team that there is a need to streamline or simplify their access into support services, provided by both the specialist sexual violence support services and mainstream and third sector services. One survivor told the Project Team *"a single place for survivors to have their needs assessed would be a great improvement. That place could then sort out what other services are needed"*. Indeed, professionals providing supporting to victims/survivors suggested that it would be beneficial if there was a single point of access for victims/survivors of sexual violence to allow for triage/assessment of the level and extent of need and then make referrals onto specialist support services, mainstream and third sector services as required.

Part 4. Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 9: Personal & Individual Requirements

“Nobody saw me as a unique person, with my own set of issues and needs. As soon as I disclosed by abuse, I was lumped into the ‘survivor’ category and told to go to a specific service for support. There was a whole load of reasons why that service wouldn’t work for me, but nobody asked about my personal circumstances.”

9.1 Those providing support to victims/survivors told the Project Team that the personal and individual requirements of victims/survivors of sexual violence are often crucial to how and when they choose to access support services. During the focus groups that were held with frontline professionals and victim/survivors, the following key themes emerged as potential barriers to accessing support:

- Age
- Ethnicity
- Sex and Gender Identity
- Sexuality
- Disabilities including physical, learning and communication difficulties
- Geography
- When the abuse occurred

Age

9.2 The Project Team was informed that the age of the individual victim/survivor will determine what services are available for them to access. It is clear that distinct services are commissioned and subsequently delivered for child victims/survivors (under 18) and adult victim/survivors (18+) and this was considered by key stakeholders to be appropriate.

9.3 In addition, the Paediatric SARC specification includes 10 sessions of therapeutic support for child victims accessing the SARC. The Project Team is aware that

Imara and NSVSS have been subcontracted to deliver this support for children in Nottingham City, meaning children are able to access immediate support. However a similar arrangement has not been put in place for children from Nottinghamshire County who are instead are referred to a service currently commissioned by the County Council from The Children's Society. The impact has been this service is currently running a one year waiting list.

- 9.4 Stakeholders raised concerns about the lack of provision for specialist sexual violence support services for children and young people. While there is a commissioned county-wide CHISVA service available for children and young people, there is a gap in therapeutic support services commissioned for children and young people. While some 'adult' services have been commissioned to deliver therapeutic support to victims/survivors who are 16+, there is a gap for younger children. As noted above the Nottinghamshire County service is now operating a one-year waiting list. In Nottingham City the Project Team have advised there is no commissioned service beyond the brief interventions following SARC attendance and therapeutic services are provided through charitable funds.
- 9.5 Key stakeholders also expressed concern about the support available to meet the needs of older people who have experienced sexual violence. A dearth of research has been conducted into sexual violence against older people, with the result that knowledge and understanding of the prevalence, characteristics and impacts is extremely limited. However, research conducted by Bows and Westmarland (2017)⁴⁴ which looked at 130 rape cases where the victim was over 60 suggests that most victims will be female, and most perpetrators will be male. Most perpetrators will be younger than the victim and is usually known to them. The abuse usually takes place in the victim's home.
- 9.6 Equality Monitoring shows between 0% and 0.8% of those accessing services are over 65 and those providing services confirmed that older people who have experienced sexual violence are a largely 'hidden' client group. In addition, they may have distinct needs that relate to how they engage with support services, for example they may have additional physical health needs and capacity issues (particularly where the victim has dementia) that need to be considered. A further breakdown of those accessing services by age is shown in the Appendices.

⁴⁴ Rape of Older People in the United Kingdom: Challenging the 'Real-rape' Stereotype Hannah Bows, Nicole Westmarland The British Journal of Criminology, Volume 57, Issue 1, January 2017, Pages 1–17, <https://doi.org/10.1093/bjc/azv116> Published: 24 November 2015

9.7 Although the commissioned sexual violence support services providing support for adults do not exclude older people from their service, the Project Team was informed that it is unclear how much or to what extent these services are able to identify and meet older people's needs.

Ethnicity

9.8 Key stakeholders raised concerns about the availability of support services for victims/survivors from black and minority ethnic refugee (BMER) communities. Specifically, key stakeholders told the Project Team that ethnicity can be an additional barrier for victims/survivors from BMER communities which may prevent them from accessing sexual violence support services.

9.9 At present the commissioned sexual violence support services referral statistics reported to commissioners show between 11.3% - 18.7% of those accessing services are from BMER communities. The outcomes achieved by these groups are not available. A further breakdown of those accessing services by ethnicity is shown in the Appendices.

9.10 Crucially, stakeholders reported that ethnicity is also a barrier for a range of other services, such as health and other services. A Health Needs Assessment⁴⁵ for the BMER populations in Nottingham City commissioned by Nottingham City Council and Nottingham City CCG in 2017, found that although BMER communities are not a homogenous group, there were key themes that prevented them from accessing support to meet their health needs.

9.11 The Project Team was informed that some victims/survivors from BMER communities often have a general perception of support services, particularly those provided in the statutory sector, as having cultural bias and/or being discriminatory. As such perception of victim/survivors from BMER communities or indeed fear of being treated inadequately because of their ethnicity is important to recognise.

9.12 Key stakeholders were unanimously in agreement that commissioned specialist sexual violence support services should be available for the whole local community as an important principle. Commissioners and providers should routinely monitor the uptake of specialist sexual violence support services to ensure access information reflects the local community that it services.

⁴⁵ <https://www.nottinghaminsight.org.uk/Document-Library/Document-Library/aAXSHua>

- 9.13 Significantly, it is important to note that stakeholders were not in agreement about what should happen where commissioned specialist sexual violence support services are not being accessed by victims/survivors from the BMER communities. While some BMER stakeholders advocate passionately for the commissioning of separate BMER-specific sexual violence services, other BMER stakeholders suggested that this would not be practical given the range of ethnicities that make up Nottinghamshire's diverse and evolving community.
- 9.14 The Project Team was informed that victims/survivors from BMER communities can - and do - access support from specific-BMER organisations and community groups principally because they have developed a trust in such services. However, these tend to be charitable organisations operating at the grassroots level, providing a range of support services (not solely support following sexual violence) who are not always well placed to meet the specifications for commissioned services for sexual violence support services. They may not, for example, have staff who are adequately skilled or qualified in responding to victims/survivors of sexual violence.
- 9.15 Stakeholders suggested that there would be benefit in commissioned specialist sexual violence support services building closer relations with BMER organisations to ensure commissioned specialist sexual violence support services are accessible to their communities. However, stakeholders were clear that commissioned sexual violence support services should not come to rely on the BMER organisations for referrals to ensure they meet any demographic requirements. For example, the Project Team was told *"when the commissioned services can't reach the BMER communities, they simply come to us and ask us to refer our clients onto them. This can't be right. They are funded to deliver a service for the whole community. We are not funded at all"*. It is clear that such approaches exacerbate hostility between commissioned and non-commissioned services and instead stakeholders suggested different approaches may make commissioned specialist sexual violence services more accessible for victim/survivors of BMER communities, including:
- Agreeing delivery models to provide outreach services from BMER organisations' premises,
 - contracting BMER organisations to train staff to be more aware of the needs of people from specific cultures or ethnic backgrounds,
 - allowing professionals from BMER organisations to attend appointments with their clients to build trust,
 - allowing professionals from BMER organisations to provide feedback to services on behalf of their clients.

9.16 The Project Team explored with stakeholders whether ensuring the workforces of sexual violence support services are reflective of the local community would help build trust amongst BME communities. The majority of stakeholders agreed that this would be a helpful step forward. *"When survivors from BME communities see a service where all the professionals are white and British, it doesn't look like it's a service for them"*. However, stakeholders also warned against services taking a 'tokenistic approach' due to the range of different ethnicities that make up Nottinghamshire's diverse community. For example, the Project Team was told *"employing one black or Asian worker, for example, won't do anything to meet the needs of the different communities that we have here and it's frankly offensive"*.

Sex and Gender Identity

9.17 While stakeholders agreed that sexual offences crimes disproportionately affect women and girls, they also recognised that men and boys are victims too.

9.18 Stakeholders told the Project Team that the commissioned specialist sexual violence supports services are largely accessible to women and girls, but they may not be fully meeting the needs of male victims/survivors. At present commissioned services referral statistics show that male victims/survivors make up between 5% - 56% of those accessing services. Less than 1% of those accessing services are transgender and the gender of the remainder are not stated. A further breakdown of those accessing services by Sex and Gender Identity is shown in the Appendices.

9.19 Broadly, stakeholders agreed that while males have different and distinct needs, their gender is often a barrier for them to access support following sexual assault in the first instance. Professionals said that gender stereo-types and the perception of 'masculinity' compound this, and suggested that their gender can be an addition barrier for males to seek and access specialist sexual violence support services.

9.20 Stakeholders both those providing and accessing services reported to the Project Team that once males do access support services, they are not always specifically designed to meet their needs. Professionals were in agreement that males will need services to meet their needs which might have to be delivered quite differently than services for females. 9.21 The Project Team explored with stakeholders whether there was a need for single-gender services. The response was mixed. One victim/survivor informed the project team *"I want to go to a*

support service for women only and that is really important to me” while another victim/survivor told us “I don’t mind at all if there are males being supported too”.

- 9.22 Stakeholders told the Project Team that assumptions about the gender of victims/survivor are often made by professionals, rather than discussing with the individual what gender they identify with. For example, professionals recognised that some people do not identify with the gender they were born with, or may not consider themselves to be the gender they ‘appear’ to be. The gender that the client identifies with might have an impact on how services can be best delivered for the individual victim/survivor. The victim/survivor may have specific requests based on their gender identity, such as a preference for a specific gender of professional supporting them, for example.
- 9.23 The Project Team was also informed that for transgender victims/survivors, the services options may change for them and this can be unhelpful, particularly at a key point in the victim/survivors life. For example, a trans male informed the Project Team *“I was able to access more services prior to transition. Some of those services became unavailable to me once I had transitioned to a male and I actually still needed them”.* Additionally, stakeholders were not clear how well specialist sexual violence support services are meeting the needs of transgender victims/survivors, despite a recognition that this group are disproportionately affected by sexual violence.

Sexuality

- 9.24 The Project Team was informed that the sexuality of the individual victim/survivor may be an important factor when accessing sexual violence support services. One victim/survivor told the Project Team *“I am a homosexual male and it’s a key part of my personality and the way I live my life. It’s really important to me that [the specialist sexual violence support service] understands this about me and doesn’t make any assumptions about me”.*
- 9.25 The Project Team was informed that not all specialist sexual violence support services consistently collect information about the sexuality of those accessing services. The reported data suggests between 3-10% of those accessing services identify as Gay or Bisexual. Some services confirmed that sometimes this information might be held on client records/notes. Stakeholders also suggested that knowledge around the individual’s sexuality might also mean that other services are available to that individual, such as voluntary LGBT Support services. A further breakdown of those accessing services by Sexuality is shown in the Appendices.

Physical Disabilities

- 9.26 Stakeholders informed the Project Team that victims/survivors of sexual violence with physical disabilities may face an additional barrier to accessing specialist sexual violence support services. For example, where a victim/survivor requires wheelchair access to attend appointments, this may limit their availability to attend services unless they have disability access. Between 20-30% of those accessing commissioned specialist sexual violence support services reported a physical disability. A further breakdown of those accessing services by Physical Disability is shown in the Appendices.
- 9.27 In addition, the Project Team was informed that victims/survivors of sexual violence may develop long-term conditions or medically unexplained symptoms as a consequence of their trauma. This correlates with finding of IICSA in its Rapid Evidence Assessment - The impacts of child sexual abuse:⁴⁶ The report suggests that the impact will vary, but victims/survivors of child sexual abuse are likely to also be accessing or in need of support from other health services as well as specialist sexual violence support services. It is unclear, as data is unavailable, what proportions of victims/survivors of sexual violence in Nottinghamshire also have long-term conditions or medically unexplained symptoms. However those providing support reported to the Project Team during focus groups and interviews that this is a common characteristic of many victims/survivors of sexual violence and abuse. The consequence of this is that as victims/survivors will often be under the care of other services, which can impact on their willingness to engage with all or some of those services.

Learning Disabilities, Cognitive Impairments or Communication Requirements

- 9.28 People with a learning disability are 'at much greater risk of sexual abuse and assault than the general population.'⁴⁷ Research shows that the incidence of abuse among people with disabilities is as much as four times higher than it is among the non-disabled population. People with a learning disability are at the highest risk of abuse.

⁴⁶ <https://www.iicsa.org.uk/key-documents/1534/view/iicsa-impacts-child-sexual-abuse-rapid-evidence-assessment-full-report-english.pdf>

⁴⁷ UK Voice, Respond & Mencap (2001) Behind Closed Doors: Preventing sexual abuse of adults with learning disabilities

- 9.29 Stakeholders informed the Project Team that victims/survivors of sexual violence with learning disabilities or cognitive impairment face additional barriers to access and engage with the specialist sexual violence support services. At present between 2 and 22% of those accessing specialist sexual violence support services report that they have a learning disability. A further breakdown of those accessing services by Learning Disability is shown in the Appendices and under individual service – identified client needs.
- 9.30 The Project Team was unclear whether the specialist sexual violence support services are effective in meeting the needs of victims/survivors of sexual violence with learning disabilities *"I know that sexual violence disproportionately affects people with learning difficulties, but I am not sure that the service is set up in a way that supports them effectively. I'm also not sure whether survivors with learning difficulties can always even find their way to us without support in the first place"*. Stakeholders suggested the importance of good links between specialist sexual violence support services and mainstream or third sector learning disability services.
- 9.31 Stakeholders told the Project Team that victims/survivors with specific communication needs of (for example, language needs, whether an interpreter or translator is needed, level of understanding or comprehension, whether the victim/survivor has a hearing impairment or use of sign-language) may be a barrier for them to access specialist sexual violence support services. There is a need to ensure interpretation is appropriate e.g. not family, friends or those from the community. The Project Team were also told of the challenges of both providing and receiving therapy via an interpreter, as there are linguistic (words and meanings) and cultural (beliefs and values) challenges.

9.32

Geography

- 9.33 . Some victims/survivors told the Project Team that they perceive access to support is affected by where the victim/survivor of sexual violence lives. Stakeholders informed the Project Team that county-wide services are often based in the city of Nottingham. However the data shows that some county-wide services are accessible with examples of outreach ISVA/CHISVA services operating in Mansfield and therapy services provided across the major towns of Nottinghamshire, Worksop, Newark, Mansfield, for example.

- 9.34 One victim/survivor told the Project Team *"there was just no way that I could go to a support service in the Nottingham. It would take me most of the day just to get there. It was never going to happen. I needed something closer to my home"*.

Occurrence of abuse

- 9.35 Stakeholders acknowledged that victims/survivors of recent sexual violence will have different options of support available to them, for example, the opportunity to collect evidence through a forensic medical examination that may no longer be available to victims/survivors of non-recent sexual abuse. Stakeholders were in agreement that all victims/survivors should be able to access a 'pathway of support' based on their individual need at the point of disclosure. One professional told the Project Team *'the opportunity for a forensic medical examination is not available for everyone, but any follow on support should be available, regardless of when the abuse took place'*.
- 9.36 The Project Team tried to establish whether victims/survivors of non-recent abuse have differing needs to victims/survivors of recent sexual abuse. Stakeholders, including victims/survivors had mixed views about any differences. For example, one professional told the Project Team *"for adults who experienced sexual abuse in childhood, they may have had unmet needs for years or even decades...which can mean they have very deep-rooted or entrenched problems, with many more support needs"*. However, both professional and victim/survivors told the Project Team that victim/survivors should not be seen as homogenous groups defined by when their abuse occurred. One professional stakeholder observed *"not all survivors of historical abuse will be impacted in the same way. Similarly, not all victims of a recent rape will react the same. Responses are very individual, very personal."*
- 9.37 Broadly, the range of stakeholders were in agreement that specialist sexual violence services should be available to support all victims/survivors of sexual violence and this should be determined by individual need, and not by when the abuse took place. Although professional stakeholders agreed that while the timeframe of the sexual abuse experience(s) may be important to understand their support needs, provide context, and identify whether they are at risk of harm, it should be individual's needs that determines what support is available to them. One professional told the Project Team *"it would be very unwise to have services for recent victims and a separate service for non-recent victims. They would probably end up doing very similar things to support their different client groups"*. Another professional told the Project Team *"Timeframes*

shouldn't be the determining criteria for access to a service, it should be needs-focused".

Offenders (not Sexual)

- 9.38 The Project Team was informed that victims/survivors of sexual violence who go on to become offenders (or who are already offenders), will have differing or additional support needs. Stakeholders informed the Project Team that for some people their experience of sexual abuse is directly linked to their offending behaviour. One survivor told the Project Team *"I physically attacked my abuser when I saw him many years later. I was arrested and then found myself with another set of problems"*. It is clear that any subsequent offending behaviour may or may not be recognised as a cause or consequence of the offending behaviour. One survivor told the Project Team *"the judge in my case realised that I was reacting to the abuse that I had suffered and part of my order was to access psychological support"* although another told us *"no, my abuse wasn't even considered. Nobody even questioned why I had committed the crime or that it was a cry for help"*.
- 9.39 Professionals in specialist and other services expressed concern that offenders may face additional risks of experiencing sexual violence from within the custody setting. One professional told us *"they may not have been sexually abused before, but there is definitely a risk [of sexual offending] once they are within the prison setting. We certainly don't know the extent of that problem"*. Stakeholders agreed that offenders who experience sexual violence should have equal access to specialist sexual violence support services. However, stakeholders were unable to confirm what support options were available to offenders. Notts SVSS confirmed that they had delivered some support to victims/survivors within a prison but this was limited.

Victims who are also perpetrators of sexual violence

- 9.40 Professionals in specialist and other services informed the Project Team that there is currently a gap in support for victims/survivors who have also been perpetrators of sexual offences. All specialist sexual violence support services confirmed that they do not provide a service for this client group. As such, it is not known the extent of this gap in provision or indeed their level of need. Professional stakeholders suggested that services provided by statutory agencies would not usually exclude perpetrators of sexual offences from mainstream support. However, many other third sector organisations do use this as exclusion

criteria. One professional told the Project Team *"we work a lot with homeless people and find that there is a large proportion who are sexual offenders who can't get support because of their offending behaviour. If they also need support for being a victim, I think they'd struggle in Nottinghamshire"*.

Part 4. Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 10: Harm from Others

“My main priority was to protect myself and my children. The professionals didn’t seem to understand this and I was offered counselling. I needed to move first and get my family to safety. Counselling came quite a long way down the list”

Survivor, Focus Group Contributor, September 2019

Information about the Perpetrator(s)

- 10.1 10.2 Stakeholders agreed that services will need to be aware of whether the victim/survivor they are supporting is in contact with the perpetrator and how frequent that contact is. For example, does the perpetrator know where they live or have access to their home or does the perpetrator contact them on social media, send text messages, emails etc. One victim/survivor told the Project Team *“nobody asked me about my relationship with my abuser. He was my children’s father, so I had to keep seeing him”*.
- 10.3 Stakeholders also suggested that it is important for specialist sexual violence support services to identify whether the victim/survivor is receiving unwanted contact relating to their abuse. For example, are they being harassed on social media, are videos, images being posted online etc. All services should consider whether the victim/survivor is at risk of harm from those who are connected to the perpetrator, such as their family members, friends, or gang members.

Domestic abuse

- 10.4 Stakeholders stated that the links between sexual violence and domestic abuse are significant. With many cases of sexual violence occurring within the domestic setting, stakeholders were agreed that specialist sexual violence support services should work closely with domestic abuse services. For example, where a client is at risk of, or currently experiencing domestic abuse, it may be necessary to refer the victim/survivor immediately to a MARAC and/or a specialist domestic abuse service or IDVA service.

- 10.5 However in the County the Project Team specifically asked those working in the police, specialist and other services about the interface between ISVA services and IDVA services and were told *"it's all a bit of a mess really. We sort it out on a case by case basis, but there is no clear process for which professional supports or when"*. The Project Team was told that many of the IDVAs across Nottinghamshire have had 4-days additional (top up) training to become ISVAs. The main focus of IDVAs is to reduce the risk of the victim, and is usually a shorter-term intervention to the support provided by ISVAs and as such the general consensus amongst stakeholders is that sexual violence cases should sit with ISVAs as soon as the risk around domestic abuse has been reduced. This may require IDVAs and ISVAs to jointly support a victim/survivor of sexual violence in a domestic setting during the period of risk. One Professional informed the Project Team *"I think some of the IDVAs would feel they could support victims/survivors of sexual violence, but I'm not sure IDVAs have the skills, the time or the understanding of the criminal justice system in the same way that ISVAs do"*.

Child Sexual Exploitation

- 10.6 The Project Team is aware that Nottinghamshire County Council has commissioned the Children's Society to provide child sexual exploitation (CSE) services (Safe Choices) as well as the previously mentioned child sexual abuse services (CSA) services (Safe Time). Stakeholders informed the Project Team that these services are operating at full capacity and that waiting lists are being applied. The Project Team has been unable to find out if there is a similar CSE service commissioned by Nottingham City Council.

Involvement in Sex Work

- 10.7 Sex workers disproportionately experience sexual violence and abuse. The Project team was informed that for those victims/survivors who are involved in sex work *"they are less likely to come forward for support and when they do, they are very hard to engage with because of their lifestyles and their lack of trust"*.
- 10.8 Data was unavailable to determine the number of sex workers across Nottinghamshire that may have been a victim/survivor of sexual violence who accessed support of specialist sexual violence support services. However, the Project Team was informed anecdotally that sex workers are more likely to access support from sex worker projects, where they have a trust in the service

providers. The Project Team was informed that there used to be a trained ISVA working in POW, a specialist sex worker service, who has recently moved on from the service.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 11: Physical Health and Medical

“The Paediatric SARC will take all child victims regardless of when the assault took place and the Topaz Centre will take adults within the forensic window. I’m not actually sure what that timeframe is though”

Professional Stakeholder, Focus Group Contributor, September 2019

- 11.1 The Topaz Centre is the adult Sexual Assault Referral Centre (SARC) for Nottinghamshire. The SARC is provided by Mountain Healthcare. The Topaz Centre is located in the grounds of a police station in the city, but is accessible without the need to enter the police building. The Project Team heard mixed views from stakeholders about the facility and its location.
- 11.2 The Topaz Centre has been commissioned by NHS England and the PCC as an acute service, meaning that it is available only to recent victims of sexual assault.
- 11.3 The Project Team was informed by the police that officers are currently rolling out refreshed information to officers about the Topaz Centre and the support they provide, which includes information about timeframes.
- 11.4 Paediatric SARC staff expressed concerns about how forensic medical examination is being described to victims/survivors. One clinician told the Project Team that she was aware that the *“parents of children have been told that the examination is internal and similar to a smear test, which is incorrect”*. Another police officer told the Project Team that he was aware that *‘victims are told that the examination can take hours and hours’*.

- 11.5 The Project Team was informed that the Topaz Centre provides follow-up calls to victims/survivors who have accessed the service to check on progress and uptake of onward referrals as required. At present the onward provision of therapeutic support is not included in the contract therefore referrals rely on existing commissioned provision delivered by the specialist sexual violence support services, IAPT and mental health services. However, those working in the SARC and victims/survivors expressed frustration that the commissioned pathways into these support organisations may differ depending on the age, gender and home address of the victim/survivor, which is confusing, both for SARC staff and victims/survivors.
- 11.6 The Paediatric SARC is delivered by Nottingham University Hospital NHS Trust at the Queens Medical Centre utilising forensically trained paediatricians and nursing staff. Crisis worker support is delivered by Notts SVSS. It is a regional service and provides medical examination to children under the age of 18 from across Nottinghamshire, Northamptonshire, Derbyshire, Lincolnshire, Leicestershire and Rutland who live in the East Midlands or have been raped/sexually assaulted in the East Midlands. The service is for children and young people under the age of 18 who have been raped or sexually assaulted, regardless of when the incident occurred. The Paediatric SARC also sees young people over the age of 18 with learning difficulties where the paediatric SARC is better suited to support them.
- 11.7 The Paediatric SARC provides a forensic medical examination to recent child victims/survivors of sexual abuse, and a non-acute service which allow children to receive a medical examination (when they are outside of the forensic window). However, clinicians expressed concerns that *'not all children are referred to [the paediatric SARC] and you have to guess that it's because police and social workers don't always fully understand that [the paediatric SARC] provides more than simply the collection of samples for evidence'*.

Urgent Medical Attention

- 11.8 The Project Team was informed that the Paediatric SARC has *"good access to urgent medical attention due to their location at QMC"*, which is the location of Nottingham's Emergency Department. The adult SARC will also facilitate access to emergency medical support for those who are accessing the SARC for urgent support.
- 11.9 Where victims/survivors have immediate medical needs, their physical welfare must be the priority. SARC staff informed the Project team that they were aware

that in some that in some cases, the victim/survivor has accessed services for urgent medical care, including the Emergency Department or 111 services, but found that they were unaware of the SARC or the pathways into them. One professional stakeholder said *"I am aware that some victims are told that the Topaz Centre is only available for those who wish to report to the police. This is incorrect as they take self referrals"*.

Forensic Medical Examination

11.10 The Project Team was informed that since the commissioning of the Topaz Centre, the availability for forensic medical examiners has improved. One professional stakeholder said *"nobody has wait hours for the doctors to arrive now, like they did previously"*. However stakeholders have advised that in some cases there is no capacity for the SARC to see victims/survivors immediately. The Project Team is aware that this is no longer caused by the availability of forensic practitioners, but instead a lack of space at the SARC and the Paediatric SARC due to the need to clean the facility between examinations to preserve forensic integrity and meet the new national forensic standards. The Project team were advised this would be addressed in the planned commissioning of a new SARC building and the re-configuration of the Paediatric SARC lay out.

Sexual Health Needs

11.11 The Project Team was informed that both the Topaz Centre and the paediatric SARC can support the sexual health needs of victim/survivors of sexual violence. The Project team was informed that STI testing, pregnancy testing and Post Exposure Prophylaxis (PEP) starter packs are available within the Topaz Centre. A referral to local GUM and sexual health clinics is made by the SARC staff according to need. In positive contrast to other areas of the county where there is often a gap for services meeting the sexual health needs of Under 13, the SARC confirmed there is an accessible and commissioned sexual health service for under 13s.

11.12 Stakeholders agreed that there is a need for a robust referral pathway between sexual health services and the specialist sexual violence support services (including the SARCs). One survivor told the Project Team *"the first service I ever accessed was a sexual health clinic. I was a child and they treated me for an STI. Nobody asked me about abuse and I think I would have told them if they had"*. Stakeholders unanimously agreed that routine enquiry into sexual violence and abuse should be rolled out to sexual health clinics .

Medical Appointments

- 11.13 Stakeholders told the Project Team that some victims/survivors will have heightened sensitivity around some medical services. For example, one victim told the Project Team *"I couldn't have a smear test because of what had happened to me"*. Professional stakeholders said that services such as maternity services, having scheduled mammograms and dental appointments can be 'triggering' for some victims/survivors.
- 11.14 The Project Team explored with stakeholders whether such mainstream services across Nottinghamshire were aware of how their services impact some victims/survivors. The response was mixed. One professional stakeholder told the Project Team *"some services are really awful. They seem to have no awareness of the impact of sexual abuse"* while another survivor said *"actually my experience of other [a mainstream] service was very good. They knew I was nervous and they were really kind to me"*. The Project Team found similar responses when asked about GPs responses to victim/survivors of sexual abuse. One victim told the Project Team *"when I disclosed my childhood sexual abuse to my GP, he told me to stop talking about it and get on with my life"* while another survivor said *"it was my GP who told me about [a specialist sexual violence support service]"*.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 12: Mental Health and Well-being

"I was referred to mental health services but they told me that my problems were too complex for them to work with. The impact on me was massive. They were basically telling me that I couldn't be fixed and that my problems wouldn't go away. I thought that if the professionals couldn't help me, then nobody can...so what is the point in carrying on"

Survivor Focus Group Contributor, September 2010

Impact of sexual violence on mental health

- 12.1 The full range of stakeholders agreed that sexual violence can have profound effects on mental health and well being, which is fully supported by research in this area. One therapist told the Project Team *"Mental health is a huge problem for survivors. It is common that some survivors of sexual violence may self-harm or become suicidal. Some will develop severe and enduring mental health problems but a large proportion will experience depression and anxiety and many will develop PTSD"*.
- 12.2 Significantly, stakeholders confirmed that poor mental health can be a consequence of sexual violence, but also a cause of the sexual violence because of the vulnerability that it creates. For example, one counsellor told the Project Team *"almost all of the people we support [in a specialist sexual violence support service] experience mental health problems or psychological distress following experiences of sexual violence, but what we don't know is to what extent they experienced this before the abuse"*. One victim/survivor told the Project Team *"Looking back, I think my poor mental health contributed to my abuse. I was an easy target"*.
- 12.3 Furthermore, the Project Team identified that access to a mental health assessment is particularly challenging in Nottinghamshire. One professional stakeholder said *"lots of our clients will report having mental health problems, but they've never been assessed and there has never been a clinical diagnosis"*. The Project Team was informed that this exacerbates difficulties in collection and

accuracy of information about mental health needs for victims/survivors. The Project Team was told that *"mental health is recorded based largely on the self identification of any mental health problems. If they tell us they have mental health problems, then we record it, but that doesn't necessarily mean that there has been any assessment or intervention."*

- 12.4 The Project Team sought to explore the clinical need of victims/survivors of sexual violence in relation to their mental health. Stakeholders said this was extremely difficult to quantify (including due to reasons explained above in section 13.3). However, the differing levels of need and indeed the severity of mental health problems is impossible to determine for the entire cohort of victim/survivors of sexual violence and abuse. One therapist explained to the Project Team *"experience of mental health problems is definitely a theme amongst survivors of sexual violence. However, they don't all have the same [mental health] needs and the severity will be different depending on a number of factors relevant to each individual"*. In addition, another professional told the Project Team it is important to acknowledge *"there are some survivors who don't experience mental health problems, so we have to be careful not to label them as such"*.
- 12.5 Stakeholders suggested that a welcome improvement would be routinely providing victims/survivors of sexual violence and abuse with a mental health assessment to determine whether there is a clinical need for mental health treatment to ensure victims/survivors can access the right support, at the right time and including the need for medication. This capability does not currently exist within commissioned specialist sexual violence support services, either at the SARC or therapeutic services. The Project Team was informed *"if we could get people properly assessed for their mental health needs, we could put the right support in place and save the wrong services from trying to pick up the pieces"*. This has also been highlighted as a need in a recent study⁴⁸ that identified the need to develop agreement on a set of national standards for mental health assessment in a SARC and mental health care that people receive on the pathway out of a SARC.

Provision of mental health services

⁴⁸ C. Brooker, et al. (2019) Journal of Forensic and Legal Medicine 68 (2019) 101862

- 12.6 Professionals and victim/survivors raised significant concerns about the provision of mental health services across Nottinghamshire and their ability to meet the mental health needs of victims/survivors of sexual violence and abuse. Broadly, stakeholders agreed that the thresholds for mental health services were unclear (particularly in relation to accessing secondary mental health services). The Project Team was informed that obtaining a mental health assessment (and diagnosis) is extremely challenging at present as a mental health assessment requires a referral via a GP and a waiting time of approximately 8-12 weeks. Furthermore, some victims/survivors described to the Project Team their personal experiences of mental health services excluded them because their needs are deemed 'too complex' for some mental health services (IAPT or Step 4) and yet do not meet levels of clinical diagnosis. One professional stakeholder told the Project Team *"the thresholds for [NHS Mental Health Services] seem to be getting higher. We know they are swamped but it seems to be harder and harder for people to access, including crisis services"*. Another stakeholder told the Project Team said *"we don't even bother trying to refer to CAMHS because their thresholds are too high"*.
- 12.7 Professional stakeholders also told the Project Team that there is confusion about historical diagnosis of personality disorder and more recent complex post traumatic stress disorder. Stakeholders said this seems to *'limit their ability to access support, while also creating confusion about what services are then available to support the needs of this client group'*. It is important to note that the Project Team was not able to verify this with commissioned mental health services.
- 12.8 The Project Team was informed that there is a general lack of awareness amongst stakeholders about what services are available through NHS mental health services. This is likely due to the commissioning of a range different providers of services involved in delivering mental health services, which led to confusion amongst stakeholders. Specifically, stakeholders (professionals and victims/survivors) when talking to the Project Team about mental health services often seemed unable to distinguish the different services available via primary care, secondary care and crisis support, and instead these services appear to be collectively described as 'mental health services'.
- 12.9 The apparent gap in provision of mental health services for victims/survivors of sexual violence has resulted in the commissioning of counselling/therapeutic services from a range of specialist sexual violence support services. One professional told the Project Team *"Our [specialist sexual violence support]"*

service is supporting extremely unwell individuals. I think we do a good job of supporting them, but some of our clients should almost certainly be under the care of mental health services...presenting high levels of risk".

Talking Therapies and Counselling Provision

- 12.10 Victims/survivors repeatedly described how they had benefited from therapy or counselling to help them on the path to recovery following sexual violence and abuse. Many victims/survivors reported having accessed more than one form of counselling over the course of a number of years. The Project Team was informed that victims/survivors wanted talking therapy services or counselling services that are not time-bound or limited by a pre-determined number of sessions. One professional told the Project Team *"it's no good giving somebody 6 sessions of counselling. Survivors can struggle to build trust and they won't have got anywhere near addressing their needs in such a short space of time"*. Conversely, another professional told the Project Team *"for some survivors, short-term counselling is all they need"*. The Project Team explored this with the range of stakeholders including victims/survivors of sexual violence and were told that a needs-led approach is required in order to determine the length (and type) of counselling required. Broadly, stakeholders were in agreement and acknowledged that the needs of victims/survivors are individual and *"what one survivors needs from counselling, won't be the same as another"*.
- 12.11 Stakeholders repeatedly informed the Project Team that the demand for counselling services is significant, particularly on specialist sexual violence support services, where waiting lists are currently in operation at Notts SVSS, ISAS, the Children's Society therapeutic services.
- 12.12 Examples were provided to the Project Team of victims/survivors who access time-bound support, complete that support but then re-enter the service to access additional support because their needs have not been met, or a life event has happened which has re-traumatised survivors who then require additional support. Given the current demand on specialist sexual violence support services, this can mean that victims/survivors are placed on waiting lists to re-access therapeutic support. Furthermore, the Project Team was told that some victims/survivors have accessed counselling from more than one specialist sexual violence support service.
- 12.13 'Counselling' is an overarching term used to describe a range of therapeutic approaches and modalities.

12.14 The counselling (talking therapies) services that have been commissioned have been specified as needing to be BACP registered, or working towards BACP registration. No specific therapeutic modalities or interventions or length of provision have been stipulated,. This means that providers are at liberty to determine the therapeutic approach or modality that is provided within the service and there can be variation in the support provided. There is no common assessment of need across the commissioned counselling services. Commissioners have stipulated the routine collection of MoJ required outcomes relating to safety, feeling informed, better able to cope with everyday life and improved health and wellbeing. No clinical outcomes are reported to commissioners.

12.15

12.16 The PCC, which has to date provided the largest amount of funding for specialist SV counselling, reports that commissioning arrangements for the therapeutic provision, with the exception of the commissioned city specialist service delivered by NSVSS, are historical arrangements which the PCC has continued to support for a number of years until a joint commissioning approach is agreed. The historical nature of these arrangements , has led to a range of different services being provided across Nottingham City and Nottinghamshire County, which in some areas has been described by stakeholders as 'piecemeal' and 'difficult to navigate'.

12.17 The Project Team is aware that work has been undertaken by commissioners to review the skill mix between Step 4 and therapeutic support delivered by the specialist sexual violence support services. The Project Team was informed that it has been determined they are comparable in terms of competence and accreditation. However it has not been possible to determine whether the levels of need or clinical outcomes between services are comparable as there is no identifier that someone has experienced sexual violence within the NHS psychotherapy and psychology services.

IAPT Pilot

12.18 The Project Team is aware that a sexual violence pathway is currently being piloted by Insight, who are commissioned by CCGs to deliver the Improving Access to Psychological Therapy (IAPT) service across Mid Nottinghamshire

(Ashfield, Mansfield, Newark & Sherwood) for common mental health problems (such as depression and anxiety disorders). For the clients who have experienced sexual violence who are referred (or self refer) to this IAPT provider, a pathway has been put in place for victim/survivors of sexual violence. This pathway includes Notts SVSS delivering support to this client group in accordance with the IAPT model.

- 12.19 The Project Team was informed that there have been implications for the training of Notts SVSS staff to deliver talking therapies in accordance with the IAPT model, given the limited number of IAPT training places across the region.
- 12.20 The Project Team was also informed that some victims/survivors have reported confusion about the sexual violence pathway of the Insight IAPT service. For example, where Notts SVSS services refer victims/survivors to IAPT, they may be referred back to Notts SVSS services as part of the sexual violence pathway. This may be the nature of the pilot, which is in its early stages, though stakeholders raised concerns about the short-term support available through the Insight IAPT pilot.
- 12.21 Since July 2019, there have been 42 people accessing this pilot service, with 13 clients completing treatment and 10 already in treatment (19 clients are waiting for treatment). Though numbers are small the recovery rate to date is 62.5%, (the national target is 50%) though all clients completing treatment have shown some improvement. Further detail on the severity of clients accessing the service and their feedback on the experience should also be reviewed alongside the process for “stepping up” or onward referral for those for whom the treatment has not demonstrated recovery.

Pre-trial Therapy

- 12.22 The Project Team is aware that the specialist sexual violence support services providing therapeutic support are aware of and adhere to the guidance on pre-trial therapy⁴⁹. This allows those who are awaiting trial to access therapy without discussing the details of the abuse or the evidence of the case and thus reducing the risk of accusations of ‘coaching a witness’.

⁴⁹ <https://www.cps.gov.uk/legal-guidance/therapy-provision-therapy-vulnerable-or-intimidated-adult-witnesses>

- 12.23 Stakeholders informed the Project Team, however, that there remains misunderstanding about the provision of pre-trial therapy amongst some stakeholders, including possibly mental health services and other counselling services in the third and private sector. This may mean that some victims/survivors may either not be given access to therapy before a trial or that the therapy does not comply with the pre-trial therapy guidelines and could potentially jeopardise criminal proceedings.
- 12.24 The CPS is currently revising the pre-trial therapy guidance, which is expected to be issued imminently. There may be changes to be implemented across the specialist sexual violence services providing therapeutic support, and public sector services.

Personal Health Budgets

- 12.25 The Project Team is aware discussions are underway with CCG commissioners regarding the potential use of personal health budgets to enable those who have experienced non-recent child abuse in an institutional setting to access therapeutic and other support. Partner agencies, therapists and psychologists expressed concern around the use of independent, private or self-employed therapists/counsellors who might have limited experience in supporting clients who have experienced sexual violence, limited awareness of their specific risks and needs or be unaware of the pre-trial therapy guidance (and the implications for clients awaiting a trial) or access to appropriate supervision. Managers suggested that in piloting such an approach, appropriate assessment of needs and agreed outcome measures to determine the appropriate level of support should be carefully considered.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 13: Coping Mechanisms and Support Networks

“Realising that there are other people who have experienced the same sort of thing that I have, really helped me. I needed to know that I wasn’t alone and that there were others like me”

Professional Stakeholder, Focus Group Contributor, September 2019

Positive & Negative Coping Skills

- 13.1 Coping skills or mechanisms are the strategies and activities that victims/survivors may use to help them deal with, work through, or process their emotions following incident(s) of sexual violence and abuse. Those supporting victims/survivors advised the Project Team of the value of supporting them to identify both positive and negative coping skills, and the importance of recognising the skills that they already have. They stated this should be part of an individual risk assessment and should form an important part of care planning.

Social Networks

- 13.2 Social Networks can also provide significant support to victims/survivors of sexual violence and abuse. Professionals informed the Project Team that support services can help by identifying any barriers to accessing existing or new support networks.

Religious or Cultural Support

- 13.3 The Project Team was informed that some victims/survivors of sexual violence will find support from religious and cultural organisations within their communities. One survivor said to the Project Team *“my church was my main supporter. They were the first people I told of my experience because I trusted*

that they would help me". As such, specialist sexual violence support services should seek to raise awareness of their services by developing links with local religious or cultural groups. For example, stakeholders suggested that some victims/survivors would be unlikely to seek support without the assistance of their religious or cultural organisation. One professional told the Project Team "we know that many of the women who access our [religious support] group are experiencing sexual violence, but they just wouldn't have the confidence or ability to access a [specialist sexual violence support group] on their own. I think we could probably do more to assist them to get to specialist support though. This would probably mean that we would have to make the calls or attend meetings with them."

Family Support

- 13.5 For the professionals and services supporting children and young people, identifying and meeting their risk and needs will involve understanding their networks of support from family or carers. The Project Team was informed that support may be required by the family members of young victims/survivors of sexual violence and abuse.

Support Groups

- 13.6 The Project Team explored with stakeholders the value of support groups for victims/survivors of sexual violence. Broadly, stakeholders (professionals and survivors) agreed that support networks are very helpful to this client group. One professional told the Project Team *"because of the nature of sexual violence, and the grooming that may have been involved, survivors can often feel totally isolated and alone. Feelings of blame, or shame can mean they don't realise there are other people who have experienced the same things they have"*. One victim/survivor told the Project Team *"coming to this service and meeting people just like me, who understand what I've been through, has been so helpful. Just being together with them, listening to them has made me realise that I am not alone and that I can get better"*.
- 13.7 Broadly, stakeholders were in agreement that there is considerable benefit in bringing together victims/survivors of sexual violence. The Project Team is aware that group therapy is available through the specialist sexual violence support services, and through non-commissioned third sector organisations. The specific types of group therapy are not outlined in service specifications, other than it

must meet the CPS pre-trial therapy guidance.. The specialist sexual violence support services appear to operate different approaches to group therapy.

- 13.8 Therapists expressed the importance that group therapy is delivered in safe environments that follow a clear programme of support. One professional reported concerns that *"group therapy should not become a place for survivors to come together to reflect on their experiences as this will potentially exacerbate negative feelings"*. Additionally, one survivor told the Project Team *"group therapy was triggering for me when other survivors talked about their experiences"*.
- 13.9 The Project Team explored the value of peer support with stakeholders, including clinicians, who broadly agreed that this can be helpful but should only be delivered as part of group therapy that is facilitated by a qualified therapist, with access to supervision and clear clinical governance arrangements in place. One professional told the Project Team *"We are deeply concerned about group work that is not professionally-led. The group therapist must have the right skills and professional experience to manage a group of survivors that does not cause further damage or encourage reliance on other members of the group or the facilitator"*.
- 13.10 Stakeholders reported concerns about the differing approaches to group therapy available across the specialist sexual violence support services and in un-commissioned services delivered by the third sector. There was agreement that group therapy should follow a structured programme of support that is consistently delivered by different providers to ensure that victims/survivors are able to access similar quality of service. Furthermore, the pre-trial therapy guidance sets out that 'un-structured groups' should be avoided. Further clarification is required about the programme structure of group work that is currently being delivered by the specialist sexual violence support and agreement a model for commissioning and delivery.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 14: Alcohol and Drug Use

"I became an alcoholic as a result of childhood abuse. Most services wouldn't help me until I had my alcoholism under control but I couldn't get it under control because I was drinking to forget. I felt like I was caught in a cycle that I couldn't break"

- 14.1 The Project Team was informed that drug and alcohol support services are commissioned in Nottingham's City by the Crime and Drug Partnership and PCC and in Nottinghamshire County by Public Health and the PCC to provide a range of support to those with drugs and/or alcohol problems. Primarily these services will provide a support/key worker role to those identifying a dependency and access to harm reduction or abstinence programmes. Some services will also provide accommodation as well as outreach services.
- 14.2 The providers⁵⁰ reported to the Project Team that drug and alcohol use can often be a 'coping mechanism' that masks other problems. Professional stakeholders from these services reported that there is a *'high volume of clients accessing our services who disclose recent and non-recent experiences of sexual violence'*.
- 14.3 Drug and alcohol services reported an awareness of the SARC (the Topaz Centre) and specialist sexual violence support services, as well as local mental health teams. However, they also acknowledged that many of their clients would be unwilling or unable to engage with these services for a range of reasons including mistrust of unknown or new services and a need to prioritise drug and alcohol problems. Significantly, the Project Team was informed that *'drug and alcohol dependency can be a barrier to services'*.
- 14.4 Stakeholders told the Project Team that *"there is definitely a will among [drug and alcohol] services to develop innovative solutions for our clients who have experienced trauma"*. NSVSS have implemented the AVA Complicated Matters

⁵⁰ Framework and Nottingham Recovery in Nottingham City and CGL in Nottinghamshire County.

Toolkit⁵¹ which aims to improve responses to survivors of sexual violence who are also affected by substance use and/or mental health problems. The Project Team was informed that a new joint approach has been developed between one IAPT provider and a drug and alcohol service to co-deliver group support that focuses on drug/alcohol reduction and common mental health problems. A co-delivery approach could be explored for victims/survivors of sexual violence who have a drug and alcohol dependency.

⁵¹ <https://avaproject.org.uk/wp-content/uploads/2013/05/AVA-Toolkit-2018reprint.pdf>

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 15: Safeguarding

“We absolutely understand that safeguarding is the golden thread that has to run through our whole service, but sometimes it’s hard to keep that thread together”

Professional Stakeholder, Focus Group Contributor, September 2019

Children and adults at risk

- 15.1 The Project Team was informed that Nottingham City Council’s safeguarding referrals are dealt with via a Multi-Agency Request for Services Form (MARF) or for adults via adult social care. Nottinghamshire County Council operates a Multi-Agency Safeguarding Hub (MASH) which brings together agencies to share information to help and protect the most vulnerable children and adults from harm, abuse and neglect. These approaches provide a single point of referral to local authorities for safeguarding concerns. Policies are regularly reviewed and updated and information is available on the Local Authorities websites.
- 15.2 Specialist sexual violence support services confirmed to the Project Team that they recognised and understood their safeguarding responsibilities where a victim/survivor of sexual violence is at risk of harm, or where they have children who are at risk of harm. Professional stakeholders told the Project Team *“the local safeguarding arrangements are clearly understood by our service and we know how to make referrals”*. The Project Team asked all of the commissioned specialist sexual violence support services about their confidence in making appropriate safeguarding referrals and no concerns were raised.
- 15.3 However, significant concerns were raised about the understanding of safeguarding requirements amongst some non-commissioned services provided by the third sector. The Project Team was concerned to be told *“some survivors won’t access the commissioned services because they are frightened that a safeguarding referral will be made. Instead they can come to us and trust that we won’t share information”*.

- 15.4 The Project Team sought to explore the links between children and adult social care with the specialist sexual violence support agencies. The feedback from stakeholders was mixed and one professional informed the Project Team *"I'm not convinced that we get all the referrals that we should from children's services"* another professional said *"I think it will depend on the awareness of the social worker. If they don't know about our [specialist sexual violence support service] then they don't make a referral. This is also our experience of the police"*. This is will be specifically relevant to the Paediatric SARC and CHISVSA service, where police and/or social services are a key referral pathway into support and in the event that there is a lack of awareness of services and access criteria, this could result in victim/survivors not having access to the full range of specialist sexual violence support provision.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 16: Criminal Justice

"I got more support when I had my ID stolen than when I reported a sexual offence"

- 16.1 Nottinghamshire Police has the responsibility for the investigation of sexual offences in Nottinghamshire. The Project Team was informed that Nottinghamshire Police have a small cadre of Specially Trained Officers (STOs) for rape and serious sexual offence investigations, with plans to expand this team. Sexual offences against children are investigated by a dedicated Child Abuse team. Operation Equinox was formed in 2015 (merging two previous investigations, Operation Xeres and Operation Daybreak) and had the remit of investigating historic child sexual abuse cases taking place within Nottingham's care homes and other care arrangements such as foster homes. Operation Equinox expanded its terms of reference to include other institutions, such as churches or schools.
- 16.2 The Project Team was informed by stakeholders from Nottinghamshire Police that they recognise the value of supporting the victim/survivor throughout the investigation. Stakeholders confirmed that *"investigation of sexual offences can take a significant amount of time, and we know that support is a crucial element of keeping victims engaged."* The Project Team was informed that the police have a system known as 'Niche' which provides them with information about local support, including specialist sexual violence support services. However, the Project Team was informed that "Niche" may not have been updated recently and may not reflect the range of support that is currently available across the city and county.
- 16.3 The Project Team explored with stakeholders the relationship between the ISVAs/CHISVAs and the police. It is the role of ISVAs/CHISVAs to provide practical and emotional support to victims/survivors of sexual violence and abuse throughout the criminal justice process (including before and during investigation and throughout and following court proceedings). The role of the ISVAs/CHISVAs was recognised by the police, with one officer describing their

role as *"completely and utterly invaluable. I cannot speak more highly of the ISVAs across Nottinghamshire. They have managed to keep victims engaged in cases that would have never got to court without them"*.

- 16.4 However, stakeholders raised concerns about the referral pathway between the police and ISVAs/CHISVAs, with professionals from both the police and ISVA/CHISVA services informing the Project Team that this interface could benefit from improvement. Specifically, the Project Team was informed that ISVA support was not yet being provided in all sexual offence cases, which may be due to a variety of reasons, including victim/survivor not consenting to their information being passed by the police to the ISVA/CHISVA service as well as individual officers lack of awareness of the ISVA/CHISVA service and the support they can provide.
- 16.5 The Project Team explored the referral to the ISVA service with the police, who said *"we do have an automatic referral form but completing it is not mandatory and parts of it can be skipped"*. Furthermore, one officer told the Project Team *"we need to make sure that there is consistent knowledge of the support available from ISVAs and CHISVAs across all our officers. Our staff changes can be tricky...but it could be done"*. This was echoed by some of the victims/survivors that talked to the Project Team who said *"the police were a gatekeeper to support. They didn't tell me about the ISVA services so I didn't know about it. I hadn't even heard of an ISVA"*
- 16.6 The police interviewed by the Project Team acknowledged the support of the ISVA and CHISVA services and agreed that there were aspects of the role that would be beneficial to them, as well as the victim/survivor. For example, one officer said *"when we provide victim updates or when we need to inform them [the victim/survivor] of NFA (No Further Action) decisions, it would be really good to have the ISVA either there or available to pick up that support"*. This was echoed by the ISVAs who told us *"we know what else is going on in the victim/survivors life, and sometimes the police input can have a really detrimental effect. The ISVAs should be aware of what is happening in the investigation and put in place support accordingly"*. One survivor told the Project Team *"the police contacted me on a Friday night when I was in the supermarket to update me on the case. I couldn't access support until the following week and it was awful"*.
- 16.7 The Project Team is aware that a national decrease in prosecution rates for rape and serious sexual offences identified by the Rape Monitoring Group (RMG) has prompted the UK Government to carry out an end to end review of rape and

serious sexual offences (currently underway). The publically available data from the RMG is not sufficient for inclusion in this needs assessment as it is nationally collated and broadly focuses on national reporting trends, charging decisions and prosecution outcomes.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 17: Employment and/or Education

"I couldn't tell my employer that I had been raped. Instead I had to say I was suffering from work-related stress just so that I could get some time off"

- 17.1 There is a wealth of research to suggest that sexual violence and abuse can have negative impacts on employment and educational attainment for victims/survivors. Evidence from a Rapid Evidence Assessment review by IICSA⁵² points to the impact of child sexual abuse affecting victims/survivors' educational attainment, employment rates and income levels. Child sexual abuse has also been associated with increased unemployment, time out of the labour market, increased receipt of welfare benefits, reduced incomes and greater financial instability.
- 17.2 Recent rape and sexual offence data from the CSEW suggests the majority of victims/survivors had taken time off work following the incident and 11% had given up work.⁵³ However, this is by no means a given and it is important to recognise that some victims/survivors use work and career achievement, or 'overwork', as a means of coping with the after-effects of abuse.
- 17.3 Stakeholders confirmed the variance of impact on employment that can be caused by sexual violence and abuse. For example, one survivor told the Project Team *"my abuse completely destroyed my education. I was tired and emotional and I couldn't concentrate at school because of the abuse that I was suffering at home. I left with no GCSEs"*, while another victim/survivor told the Project Team

⁵² IICSA CSA Impact Rapid Evidence Assessment <https://www.iicsa.org.uk/key-documents/1534/view/iicsa-impacts-child-sexual-abuse-rapid-evidence-assessment-full-report-english.pdf>

⁵³ Table 31 CSEW Table 31: Impact on work of rape or assault by penetration

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffencesappendixables>

"I was a really high achiever. I threw myself into studying and then work and found that working was a release from my past experiences."

- 17.4 Significantly, more than 20% of respondents to the needs assessment survey cited having needs around employment and education. Significantly, this proportion of survey respondents continued to identify this, as an area of support needs when they were in contact with services, suggesting this continues to be an area of unmet need.
- 17.5 Stakeholders told the Project Team that ISVAs and CHISVAs can and do assist victims/survivors of sexual violence and abuse around employment and education. Specifically, they can support the victim/survivor to inform education providers and employers, and support with access to occupational health, employment support and/or benefits.

Schools and Colleges

- 17.6 All schools/colleges must have an identified Safeguarding Lead whose role and responsibility is to provide recognition and referral as well as enacting any recommendations from support organisations. Feedback from support organisations is that schools/colleges are generally supportive in providing accommodation for meetings, supporting multi-disciplinary assessments and strategy meetings. Stakeholders informed the Project team that previously school counsellors, nurses and even teaching assistants were able to provide some on-going support. However, the reduction in these roles across education has had an impact on the support that is available across the education sector. Furthermore, stakeholders suggested that it would be unusual for these staff to have a specialism or competency in supporting victims/survivors of sexual violence, even when they have dealt with such cases previously.
- 17.7 The CHISVA service reports they have successfully liaised with schools to provide additional support for children and young people who have experienced abuse including identifying additional support or alternative provision where necessary. A key outcome for young victims and survivors is to ensure they are able to continue their education and training.

Higher Education Institutions

- 17.8 There are two universities within Nottingham with large student populations:
- Nottingham Trent University (26,848)
 - University of Nottingham (44,050)
- 17.9 Both Universities report an increase in the number of reports of sexual violence, including non-recent and peer on peer. This is largely due to an increased willingness of universities to encourage students to disclose experience of sexual violence and to promote a safe environment where harmful sexual behaviours will not be tolerated. Figures from the Universities were not available.
- 17.10 Both universities informed the Project Team that they have dedicated staff within their Welfare Teams, specially trained⁵⁴ as Sexual Violence Liaison Officers (SVLOs) to respond to student and staff members who have experienced recent or non-recent experience of sexual violence. The role of the SVLO is to provide support to the reporting student/staff member around their university life (for example, accommodation, finance, academic requirements or adjustments and any internal disciplinary proceedings or university's investigations into sexual misconduct).
- 17.11 The SVLO will refer to support either internally to the university or within the local community to provide support as required. The Project Team was informed that SVLOs can refer SARC, ISVA and therapeutic services.
- 17.12 The Project Team was informed by those working in the Welfare Teams that *"the needs of students will largely be similar to other victims/survivors of sexual violence, however, the impact on their academic education is significant, as this can affect their accommodation and finances in a way that it wouldn't affect others. Students are often away from home and this impacts on their vulnerability."*
- 17.13 It was reported to the Project Team that both Nottingham Trent University and The University of Nottingham have significant populations of international students whose language and cultural barriers can present a challenge both to disclosure and accessing support. One professional said *"You may be able to speak enough English to complete your accountancy degree but may not have the words or confidence around reporting a sexual offence"*. In addition, some groups in the student community *"have a distrust of the police or statutory services in*

⁵⁴ Accredited SVLO Training provided by LimeCulture CIC

their own countries which continues when they come to study here". The Project Team was informed that the impact of sexual violence and abuse on their studies can be considerable as they are unable to take a break from studies and travel home due to distance or a fear of being shamed and blamed. Furthermore, international students on a student visa may have No Recourse to Public Funds, which may limit their actual or perceived access to specialist sexual violence support services or other mainstream or third sector services outside of the university setting.

- 17.14 The Project Team explored the interface between the specialist sexual violence support services, specifically ISVAs and the SVLOs within the two universities. The Project Team was informed *"more could be done to create better links and relationships between the SVLOs and ISVAs in particular. We are a route of referral for them and them for us. We should be working together more effectively"*
- 17.15 In relation to prevalence of sexual violence amongst UK students, Universities UK report *Changing the Culture* (2015)⁵⁵ acknowledged that there is no comprehensive data available to indicate how many UK university students are affected by incidents of sexual violence. However, given the size of the student populations in Nottingham the Project Team is of the view that both universities should be included in any local strategy or operational groups that relate to victims/survivors of sexual violence and abuse.

⁵⁵ <https://www.universitiesuk.ac.uk/policy-and-analysis/reports/Pages/changing-the-culture-final-report.aspx>

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 18: Finances

"I was living with my partner working in his business so when the abuse got so bad, I left and I lost my job and my home at the same time. Going into the Job Centre to claim Job Seekers Allowance was one of the scariest days of my life. I had an immediate panic attack.

Survivor Focus Group Contributor September 2019

- 18.1 Many of the victims/survivors that engaged with the Project Team described themselves as having limited finances, dependent on long term health and social care benefits.
- 18.2 Support around finances and benefits was one of the areas identified by 20% of victims and survivors both in the survey for this needs assessment and in the need assessments carried out by specialist sexual violence support services. Significantly, survey results showed that a significant proportion still identified need in these areas even where they had accessed specialist sexual violence support services.
- 18.3 Stakeholders informed the Project Team that lack of finance will limit victims/survivors of sexual violence and abuse ability to access support services where these are not close to home. One parent of a child victim of sexual abuse told the Project Team *"we were only able to access support close to home otherwise it would mean a bus, and I couldn't afford that"*. In one case the Project Team was advised of a parent who did not want to attend the SARC as she was worried about being stranded in Nottingham. Another survivor told the Project Team *"when I left my abuser, I lost all access to money and I had no idea what to do"*
- 18.4 The Project Team was informed that the ISVA service provides support around benefits entitlement and finances. However, it was suggested that more close relationships could be built with DWP Job centres to ensure advice in this area is available to victims/survivors of sexual violence.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 19: Accommodation & Housing

“Ensuring survivors have safe housing is a fundamental need. Unfortunately, its not always very easy to arrange this for them”

Professional Stakeholder, Focus Group Contributor, September 2019

- 19.1 The Independent Inquiry into Child Sexual Abuse (IICSA) has suggested that there are possible links between CSA victimisation and homelessness and/or housing issues during both youth and adulthood.⁵⁶ However, IICSA has recommended further research to better understand this area of need.
- 19.2 The Project Team was told by stakeholders as part of this needs assessment that for those experiencing sexual violence and abuse there is often an impact on housing. This is particularly significant for those victims/survivors (and their children) in the context of domestic violence. However, stakeholders explained that this is an issue that is solely related to domestic abuse as it *“may affect other victims too where there is a need to move or relocate for safety or other reasons”*.
- 19.3 Around a quarter of those surveyed for this needs assessment identified housing needs. Significantly, most of these rated their access to support for housing and accommodation as poor or very poor and more than a quarter of the survey respondents continued to identify needs around accommodation and housing following access to support services.

⁵⁶ ⁵⁶ IICSA CSA Impact Rapid Evidence Assessment <https://www.iicsa.org.uk/key-documents/1534/view/iicsa-impacts-child-sexual-abuse-rapid-evidence-assessment-full-report-english.pdf>

Supportive Housing

- 19.4 Professional stakeholders from Homeless and Housing organisations told the Project Team that they are concerned about their clients with multiple or complex needs and the risk of sexual violence and abuse or exploitation. One professional stakeholder told the Project Team *“we have a duty to protect other residents and that might result in an eviction. For those people, the risk of sexual exploitation is concerning to us”*. Another professional stakeholder told the Project Team *“when we house vulnerable people, we find that statutory agencies often back off. There is an expectation that we will address their needs but or it isn’t possible to do everything to protect them.”*
- 19.5 The Project Team was informed about specific concerns relating to young people in particular (18-24 year olds) and adults who are homeless who have experienced sexual violence and abuse. One professional stakeholder told the Project Team *“for children safeguarding arrangements are in place, but for 18 year olds this becomes messy, what would previously have been deemed exploitation is now deemed unwise choices”*. The Project Team was informed about a case of a victim of a recent sexual offence who was homeless. The [specialist sexual violence support] service told the Project Team *“we couldn’t discharge her because she had nowhere to go, but it took a long time and a lot of calls before somebody from housing would come out.”*
- 19.6 The Project Team was informed that there would be benefit in ensuring referral pathways are put in place between specialist sexual violence support services and housing support services to ensure that victims/survivors can have their housing needs assessed and access by housing-specific advice and support services.

Part 4: Needs of Victims/Survivors of Sexual Violence and Abuse

Chapter 20: Immigration and Residency

“Those with no resource to public funds are extremely challenging to support in relation to experiences of sexual abuse”

Professional Stakeholder, Focus Group Contributor, September 2019

- 20.1 Stakeholders expressed significant concerns about supporting clients with restrictions to their immigration status with experiences of sexual violence and abuse. Victims/survivors may have experienced sexual violence in their home countries, during the trip to the UK or once they are in the UK. One professional told the Project Team *“they often don’t know about or trust services and this is a barrier to them seeking help in the first place. If they do happen to come forward, they may not have the right to access support anyway”*.
- 20.2 The Project Team was informed that victims/survivors who have no recourse to public funds include those who have entered on a Spouse visa, student visa, limited leave granted under family or private life rules or where leave to enter or remain in the UK that is subject to a maintenance undertaking e.g., a dependent relative of a person with settled status (five year prohibition on claiming public funds).
- 20.3 The Project Team was informed of the value of safe spaces and culturally appropriate support to build trust amongst those who have experienced sexual violence and abuse to disclose sexual violence and abuse. Stakeholders said there is a willingness for such services to work with specialist sexual violence support services, but the awareness of such provision is not well understood by all groups.

Trafficking and Modern Slavery

- 20.4 The Project Team was informed that Nottingham and Nottinghamshire Modern Slavery Partnership involves both Nottingham City and Nottinghamshire Councils with a range of other organisations working together to support this initiative.
- 20.5 The Project Team notes the last Need, Risk and Prevalence Assessment⁵⁷ for modern slavery was completed in 2016. Neither this Assessment nor the most recent Police and Crime Needs Assessment identified that sexual exploitation was a feature of Modern Slavery or Human Trafficking In Nottinghamshire.

⁵⁷ Modern Slavery Understanding Prevalence, Risk and Victim Need - <https://www.nottinghamshire.pcc.police.uk/Document-Library/Public-Information/Newsletters-and-Publications/Publications/Modern-Slavery-in-Nottingham-and-Nottinghamshire-2016.pdf>

20.6 The Project Team was informed that Nottingham is one of the pilot areas for individuals referred from the National Referral Mechanisms for Human Trafficking, which include assessment for needs and risks around experience of sexual violence. Stakeholders reported to the Project Team that there are significant national delays in this process, which have resulted in a focus of the team of more local trafficking or exploitation. These may not be individuals trafficked from other countries but vulnerable adults who are subject to trafficking across County Lines or Cuckooing, where a vulnerable adult may be subjected to financial abuse having their benefits taken or accommodation used for illegal activities.

Key Findings & Recommendations

The key findings of this needs assessment have been ascertained by the Project Team through careful analysis of prevalence data relating to sexual violence, reported sexual offence data as well as data and information provided by a range of sexual violence support services. The Project Team have consulted widely to obtain views and experiences from a wide range of stakeholders (professionals and victims/survivors of sexual violence and abuse).

It is suggested that the recommendations contained within the report are used by Commissioners to inform their decision-making around how service provision for victims/survivors in Nottinghamshire is configured, designed, and funded moving forward.

Key Findings

Governance

The Project Team is aware that there has been a concerted effort by the range of local commissioning authorities to work together to improve the response to sexual violence across Nottinghamshire. However, the current governance structure should be reviewed to ensure that commissioning authorities are able to jointly monitor the implementation of the NHS Sexual Abuse and Assault Strategy, ensure equitable pathways to high quality support services are available across all of Nottinghamshire, and assure the effectiveness of commissioned specialist sexual violence support services through the monitoring of all relevant data.

Data

Victim/survivors present to a wide range of public and third sector services that do not collect data on sexual violence and abuse. This has hampered the effectiveness of the data collection for this needs assessment. There is a need for data to be routinely and consistency collected by public sector and commissioned third sector services. To be effective and safe, this data collection should be supported by a strategic programme of training in sexual violence as well as routine enquiry.

Strategic commissioning

Historic arrangements have led to a number of different services being available for victims/survivors of sexual violence across Nottinghamshire which is inequitable and may result in varying quality of provision.

The Project Team believes specialist sexual violence services are required and should be jointly commissioned by the range of commissioners with responsibility (Local Authorities, NHS England, PCC and CCGs) to ensure that there is a consistent approach to service provision and quality across the city and county, for adults and child victims of sexual violence and abuse. As part of a partnership approach, different commissioning authorities may take the lead on behalf of the other commissioners for specific services or elements of service.

Operational

Due to the range and complexity of needs that victims/survivors might have, it is clear that the commissioned sexual violence support services cannot – and do not - provide the whole package of support required by victims/survivors of sexual violence, and there is a need for victims/survivors to access other services to address any wider needs they may have which may include services addressing and responding to domestic abuse, physical, sexual and/or mental health needs, education/employment, housing, financial support and immigration support. As well as any special needs relating to personal characteristics which might include language, disability, religion.

It is, therefore, important that there are arrangements put in place, with clear referral pathways, clarity on access criteria for such services, information sharing agreements formalised through service level agreements, between services to enable victims/survivors to have timely access to the services they need.

Future services

The creation of a 'coordination hub' has been suggested as an opportunity to ensure that victims/survivors are able to access information and have their individual needs assessed, with onward referral to alternative or additional services to then meet these needs. The Project Team explored this idea further with a range of stakeholders, including victims/survivors and professionals from a range of services. Stakeholders described the benefit of a single 'coordination hub' that could provide the following:

- Helpline/Information (for victims/survivors and professionals)
- Referrals from professionals in other services e.g., drug and alcohol, housing, sexual health etc
- Self-referral from victims/survivors
- Assessment of risk and/or needs including mental health assessment
- Development of individuals support plans
- Coordination of referrals to (or delivery of) specialist sexual violence support services
- Coordination of referrals to other services to meet victim/survivors needs.

It should be noted that the activity provided by a 'coordination hub', as suggested by stakeholders, is similar to that of the role of ISVA/CHISVA. In addition, activities provided by the hub are to a certain extent already delivered by some specialist SV services as part of their counselling contracts.

Mental health support

While this needs assessment identified that victims/survivors may each have differing range of needs, it clearly identified the impact of sexual violence on mental health and well-being. It is crucial that services to support victims/survivors of sexual violence with their mental health needs are available. This needs assessment identified problems for victims/survivors in accessing mental health services

The Project Team is of the view that more needs to be done to address the complex mental health needs of victims/survivors of sexual violence, who may not be getting the right level or type of support based on their needs.

This needs assessment recommends that mental health assessments should be available to all victims/survivors to determine their level of need and allow access to the right service including secondary mental health care and medication at the right time.

It is clear that this apparent gap in provision of mental health services accessible to victims/survivors of sexual violence has resulted in the commissioning of counselling/therapeutic services from a range of specialist sexual violence support services, in an attempt to meet the gap. However, no therapeutic modalities or interventions have been specified for these services, they are not the same across City and County: they assess survivors differently, and the length of sessions provided varies. In addition, existing services are reporting waiting lists of up to a year in some services, which survivors report is too long to wait for support.

The Project Team therefore recommends that commissioners should better understand the capacity of these specialist SV therapeutic services and review the assessment process, provision of and clinical effectiveness of the existing services..

In addition, a review of the therapeutic interventions on offer within specialist sexual violence support services should be conducted to ensure that therapies are evidence-based and effective to this client group based on their mental health needs. The Project Team acknowledges difficulties in this due to the lack of NICE guidance specifically for victims/survivors of sexual violence. However, the relevant guidance (for example, PTSD and Depression and Anxiety guidance) should be adhered to by services offering counselling and therapeutic support (see Appendix F).

Future service specifications should ensure that outcome measures are clearly identified and monitored alongside the therapeutic approach that is provided. This will begin to allow the identification of modalities or therapeutic approaches that do or do not meet the needs of victims/survivors of sexual violence.

Sexual Assault Referral Centre (Topaz Centre)

The SARC has been commissioned as an acute service. The Project Team was concerned by the number of stakeholders (including police) who made references to the service only being available to victims within the 'forensic window'. There appeared to be wide-spread confusion about what this term actually means. As a result, the Project Team is concerned that some victims/survivors who could benefit from the SARC, may not be referred. This needs reviewing. In addition, given that the SARC is the first point of support for a number of victims/survivors, the SARC should be closely aligned with any such coordination hub.

ISVA/CHISVA Services

The feedback from stakeholders about the role of the ISVA/CHISVA services was excellent. However, the Project Team is concerned that there is some confusion about the role of the ISVA amongst stakeholders including the police. Some stakeholders were not always aware that the ISVAs could support victims/survivors who have chosen not to report to the police, for example. Additionally, the Project Team was informed, both in the survey and focus groups, that not all victims/survivors who could have accessed the support of the ISVA service have been referred to the ISVA service.

The Project Team is aware nationally that referrals to ISVA and CHISVA services continue to increase, particularly as their service becomes better known and understood by professionals in mainstream and third sector and by victims/survivors who may wish to self refer. The Project Team is concerned about the potential increase in demand for the ISVA and CHISVA services and what impact this will have on them to deliver their essential support services.

Based on the data around prevalence and police reports the current number of commissioned ISVAs and CHISVAs services may quickly become insufficient to provide safe support. As such, the Project Team suggest that further work is done to look at the likely demand for the ISVA and CHISVA services in Nottinghamshire moving forward. This should include work to ensure that ISVA provision is accessible to sex workers.

Strategic training

This needs assessment also highlighted the need for awareness training amongst professionals in mainstream and third sector organisations about the impact of sexual violence and abuse, and include support around recognising signs and symptoms of abuse. This needs assessment identified that some professionals do not always have the confidence to discuss sexual violence with their clients and are not always aware of the specialist sexual violence support services available across Nottinghamshire. Building on the work already started in the County, routine enquiry into sexual violence and abuse should be introduced across these services. This must be underpinned by a strategic training programme which builds professionals' understanding of sexual violence, challenges myths and assumptions, enables professionals to respond to disclosure appropriately and ensure they understand how to refer to commissioned services.

Recommendations

As part of this needs assessment, the LimeCulture Project Team has made the following recommendations:

Governance

Recommendation 1 - Current governance arrangements should be reviewed to ensure commissioning authorities are able to jointly monitor the implementation of the NHS Sexual Abuse and Assault Strategy, pathways of support (including referrals) across all of Nottinghamshire and the effectiveness of commissioned specialist sexual violence support services through the monitoring of all relevant data.

Strategic Commissioning

Recommendation 2 - Specialist sexual violence support services should be jointly commissioned by the range of commissioners with SAAS responsibilities (Local Authorities, NHS England, PCC and CCGs) to ensure that there is a consistent approach to service provision and quality across the city and county for adults and child victims of sexual violence and abuse, with different commissioning authorities taking the lead (on behalf of the other commissioners) for specific services or elements of service.

Recommendation 3 – As part of recommendation 2, CCGs should provide funding for mental health services and therapeutic support services for victims/survivors of sexual violence (including those delivered by the specialist sexual violence support services in the third sector).

Recommendation 4 - Nottingham and Nottinghamshire Modern Slavery Partnership should be asked to inform commissioners with responsibility for sexual violence and abuse if there is any intelligence around increased prevalence/activity that could inform future commissioning.

Future services

Recommendation 5 - Commissioners should consider adopting a 'coordination hub' to assess need, triage and manage referrals for victims/survivors of sexual violence.

Recommendation 6 - The provider of the new co-ordination hub (if commissioned) should develop a pathway (or colocation in the coordination hub) to DWP benefits advice to ensure that the financial needs of victims/survivors are being met. It should also ensure that it has a formal pathway to housing support, with information sharing agreements in place.

Recommendation 7 - Commissioners should ensure that victims/survivors have access to mental health assessments within specialist SV services to avoid survivors having to access support through GPs, accurately identify the level of need in relation to mental health and be able to be referred into NHS mental health services when appropriate.

Recommendation 8 - As part of the joint commissioning arrangements commissioners should review the provision, demand and clinical effectiveness of therapeutic support (counselling) provided to victims/survivors of sexual violence to inform future services. This should include a review of the IAPT pilot and the personal health budgets for IICSA related survivors.

Recommendation 9 – Commissioners should agree and commission a model of therapy delivery that provides a structured programme of support, with routine clinical outcome monitoring, and which allows victim/survivors of sexual violence with mental health needs to access the right services at the right time, including medication. This should include survivors with personality disorder and complex post-traumatic stress disorder. The new model must fully meet the new pre-trial therapy guidance.

Recommendation 10 - Commissioners should review the commissioning arrangements for specialist sexual violence support services for child victims of sexual violence, and take urgent action to address the gaps in provision for therapeutic support and potential gap in a commissioned CSE service in some areas..

Data collection, routine enquiry and training

Recommendation 11 - Commissioners should ensure that data is routinely and consistently collected by public and third sector services about the number of service users accessing their services who have disclosed sexual violence. This should be implemented alongside awareness training for professionals.

Recommendation 12 - A strategic sexual violence awareness training programme should be developed and delivered to staff in public and third sector organisations which builds professionals' understanding of sexual violence, challenges myths and assumptions, enables professionals to respond to disclosure appropriately and ensure they understand how to refer to commissioned services.

Recommendation 13 - Routine enquiry into sexual violence and abuse should be introduced across public sector and third sector services. This must be underpinned by adequate training.

Operational

Recommendation 14 – Commissioners and commissioned providers should continue to publicise information about specialist sexual violence support services to public and third sector organisations across Nottinghamshire. This should include access criteria and referral information.

Recommendation 15 – Commissioned sexual violence providers should explore better use of information sharing agreements to support victim/survivor engagement with public and third sector services that reduces the need for the repeating of sensitive information.

Recommendation 16 – Commissioners and providers should monitor the effectiveness of specialist sexual violence support services in meeting the needs of all of

Nottinghamshire's populations who have experienced sexual violence and abuse, including female, male, transgender, older people, BMER, LGBT survivors, disability. . This should include ensuring providers take action to address any gaps.

Recommendation 17 - Commissioners should ensure that support is available to all victims/survivors of sexual violence who are offenders, recognising the need to meet security requirements for support delivered within the prison estate.

Recommendation 18 – Nottinghamshire Police should review the referral process from the police to the ISVA/CHISA services to ensure that referrals are made in all appropriate cases.

Recommendation 19 - Commissioned SV and DVA providers should review the interface between IDVA services and ISVA services to ensure the victims/survivors of sexual violence in a domestic setting are appropriately supported. The Project Team recommend that this should be risk-focused, e.g., IDVAs lead on reducing the risk of domestic abuse and then hand over to ISVAs to provide practical and emotional support around the sexual violence aspects.

Recommendation 20 – Commissioned providers should consider the findings of this needs assessment in relation to BMER survivors, and ensure they build relationships with BMER organizations to support survivors better.

Recommendation 20 – The ISVA provider should ensure that the ISVA service is accessible to clients who may be involved in sex work.

Recommendation 21 - The relationship between Sexual Violence Liaison Officer - SVLOs (in Nottingham University and Nottingham Trent University) and ISVA service should be developed with clear referral pathways, information sharing agreements and agreed operational practices.

Recommendation 22- The SARC provider should ensure that there is clarity amongst the range of services (including specialist sexual violence support services, mainstream and third sector service) about the services provided by the Topaz Centre.

Recommendation 23 - Providers of sexual violence support services should develop better relationships with drug and alcohol services to facilitate access to support. Co-delivery approaches should be explored to support victims/survivors of sexual violence who have drug and/or alcohol dependency.

Recommendation 24 – All commissioned sexual violence providers should raise awareness of support services with grassroots organisations supporting those with immigration needs.

Recommendation 25 - Commissioners should maintain a watching brief on the outcomes from the national end-to-end review of rape and serious sexual offending. Any recommendations should be recognised, considered and implemented locally where appropriate.

Annex A. About LimeCulture Community Interest Company

1. LimeCulture Community Interest Company (CIC) is a national sexual violence organisation based in the UK. We work with frontline professionals, and their organisations, to improve the response to victims of sexual violence, through our range of training and development initiatives, research, and specialised consultancy services.
2. We believe that all victims, regardless of where they live, their age, belief, gender or sexual orientation, should have access to high-quality, safe and effective support services. To this end, we are committed to working with professionals and services to ensure they have the tools, knowledge, skills, competence and confidence to respond effectively, professionally and safely to safeguard the welfare of children and adults affected by sexual violence.
3. Established in 2011, LimeCulture quickly evolved into the UK's leading sexual violence training and development organisation. Through our breadth of professional knowledge and experience of working across the sexual violence sector, we are able to support our customers to deliver excellent services to victims of rape and sexual assault.
4. The Project Team for this needs assessment included:
 - Stephanie Reardon, Joint CEO
 - Becky Dewdney York, Programme Manager
 - Charlotte Bond, Accreditation Manager
 - Gemma Kirby, Training and Development ManagerInformation and advice was provided by Kim Doyle, Joint CEO and Bernie Ryan, Director of Training and Development).

1. BAC-IN
2. Building Bridges Breaking Barriers
3. Change Grow Live
4. Chayah
5. Eden Heart
6. Framework
7. Imara
8. Insight
9. ISAS
10. Mojatu
11. NHS England
12. Nottingham City Council
13. Nottingham Counselling Service
14. Nottingham Muslim Women's Network
15. Nottingham Refugee Forum
16. Nottingham Sexual Violence Support Service
17. Nottingham Trent University
18. Nottinghamshire Child Sexual Abuse Survivors Group
19. Nottinghamshire County Council
20. Nottinghamshire Healthcare NHS Foundation Trust
21. Nottinghamshire OPCC
22. Nottinghamshire Police
23. POW
24. SHE-UK
25. Support for Survivors
26. The Children's Society
27. Trent PTS
28. University of Nottingham
29. Women's Aid – Refuge Services and IDVA Services

Annex C: Equalities Monitoring from Commissioned Specialist Sexual Violence Support Services

	ISVA Service	CHISVA	SSS	NSVSS (Counselling)	ISAS	SARC	PSARC
Gender							
Male	9.0%	16.0%	55.8%	12.0%	19.5%	5.3%	9.8%
Female	90.0%	84.0%	44.2%	87.0%	80.2%	83.2%	89.4%
Trans/Non Binary	0.0%	0.0%	0.0%	1.0%	0.3%	1.1%	0.8%
Not Stated	0.0%	0.0%	0.0%	1.0%		2.2%	
Ethnicity							
White British	72.3%	56.8%	79.2%	71.2%	64.1%	52.4%	58.5%
White Irish	0.9%	0.0%	2.6%	0.8%	0.6%	0.0%	0.8%
White Gypsy or Irish Traveller	0.4%	0.5%	0.0%	0.2%	0.9%	3.3%	0.0%
White Other	2.3%	2.0%	0.0%	1.9%	0.0%	0.0%	2.4%
Mixed White & Black Caribbean	1.1%	4.5%	5.2%	2.6%	4.6%	3.1%	1.6%
Mixed White and Black African	0.2%	0.5%	0.0%	0.3%	0.0%	0.0%	0.8%
Mixed White and Asian	0.9%	0.0%	0.0%	1.0%	0.3%	0.0%	0.0%
Mixed Other	0.4%	3.0%	1.3%	1.8%	4.0%	2.2%	0.0%
Asian Bangladeshi	0.4%	0.5%	0.0%	1.0%	0.0%	0.0%	1.6%
Asian Indian	0.4%	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%
Asian Pakistani	0.8%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%
Asian Chinese	2.3%	0.0%	0.0%	0.3%	0.0%	0.4%	0.8%
Asian Other	0.2%	1.5%	0.0%	2.1%	0.0%	0.0%	0.0%
Black African	0.6%	0.5%	0.0%	2.2%	0.3%	1.3%	1.6%
Black Caribbean	1.7%	1.0%	2.6%	1.4%	0.6%	0.0%	0.8%
Black Other	1.7%	0.0%	2.6%	2.3%	0.0%	2.0%	0.0%
Arab	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Ethnic Group	0.9%	0.0%	1.3%	0.3%	0.0%	0.0%	0.8%
Unknown / Not Specified	12.3%	29.1%	5.2%	10.1%	24.6%	35.0%	30.1%
TOTAL BME	11.7%	14.1%	15.6%	18.7%	11.3%	12.6%	11.4%
Age							
0-3		2.5%					27.6%
4-6		7.5%					10.6%
7-9		10.6%					12.2%
10-12		11.6%			0.0%		28.5%
13-17		24.1%		6.7%	0.9%	0.7%	21.1%
18-24	43.4%	16.6%	6.5%	28.5%	9.7%	47.2%	
25-34	23.9%	2.0%	5.2%	22.0%	19.8%	35.1%	
35-44	15.5%	3.0%	13.0%	18.7%	26.4%	0.0%	
45-54	11.9%	4.5%	48.1%	16.3%	28.3%	9.1%	
55-64	4.5%	0.0%	13.0%	4.8%	10.9%	0.0%	
65-74	0.6%	0.5%	13.0%	0.3%	3.0%	0.9%	
75+	0.0%	0.0%	0.0%	0.0%	0.9%	0.0%	
Unknown / Not Specified	0.2%	0.0%	1.3%	2.8%		7.1%	
Over 65	0.8%	0.5%		0.3%		0.9%	n/a

	ISVA Service	CHISVA	SSS	NSVSS (Counselling)	ISAS	SARC	PSARC
Disability							
Physical	4.4%	16.1%	3.9%	9.5%	16.7%		0.8%
Mental health	36.9%	1.0%	33.8%	20.7%	66.0%		20.3%
Learning or development	8.5%	2.5%	3.9%	7.9%	22.2%		4.1%
Multiple	10.0%	11.1%	41.6%				9.8%
No Disability	21.0%	1.5%	13.0%	42.2%			65.0%
Unknown / Not Specified	19.1%	35.2%	3.9%	10.7%	2.4%		
Long Term Health	100.0%	48.7%			29.5%		
Disability Total	59.8%	30.7%	83.1%	38.2%	66.0%		25.2%
Sexual Orientation							
Heterosexual / Straight	57.0%	5.0%	68.8%	74.5%	63.2%	54.1%	
Lesbian / Gay	2.7%	1.5%	1.3%	3.4%	4.0%	2.4%	
Bisexual	3.4%	0.5%	1.3%	6.8%	0.3%	4.4%	
Other	0.2%	0.0%	0.0%			0.0%	
Unknown/Not specified	36.7%	93.0%	28.6%	15.2%	32.5%	39.0%	
LGBT	6.3%	2.0%	2.6%	10.3%	4.3%	6.9%	
Religion							
No religion	36.2%	10.1%	32.5%	58.8%	30.7%		
Christian	8.5%	2.5%	7.8%	19.2%	0.0%		
Buddhist	0.4%	0.0%	0.0%	0.3%	0.0%		
Hindu	0.2%	0.0%	0.0%	0.4%	0.0%		
Jewish	0.0%	0.0%	0.0%	0.3%	0.3%		
Muslim	1.5%	0.5%	0.0%	2.3%	0.0%		
Sikh	0.4%	0.0%	0.0%	0.6%	1.5%		
Other	3.2%	0.5%	10.4%	1.7%	20.7%		
Unknown/Not specified	49.6%	86.4%	49.4%	16.3%	46.8%		

Annex D: Findings from the Online Survey

Figure 1 Who completed the survey? (n=52)

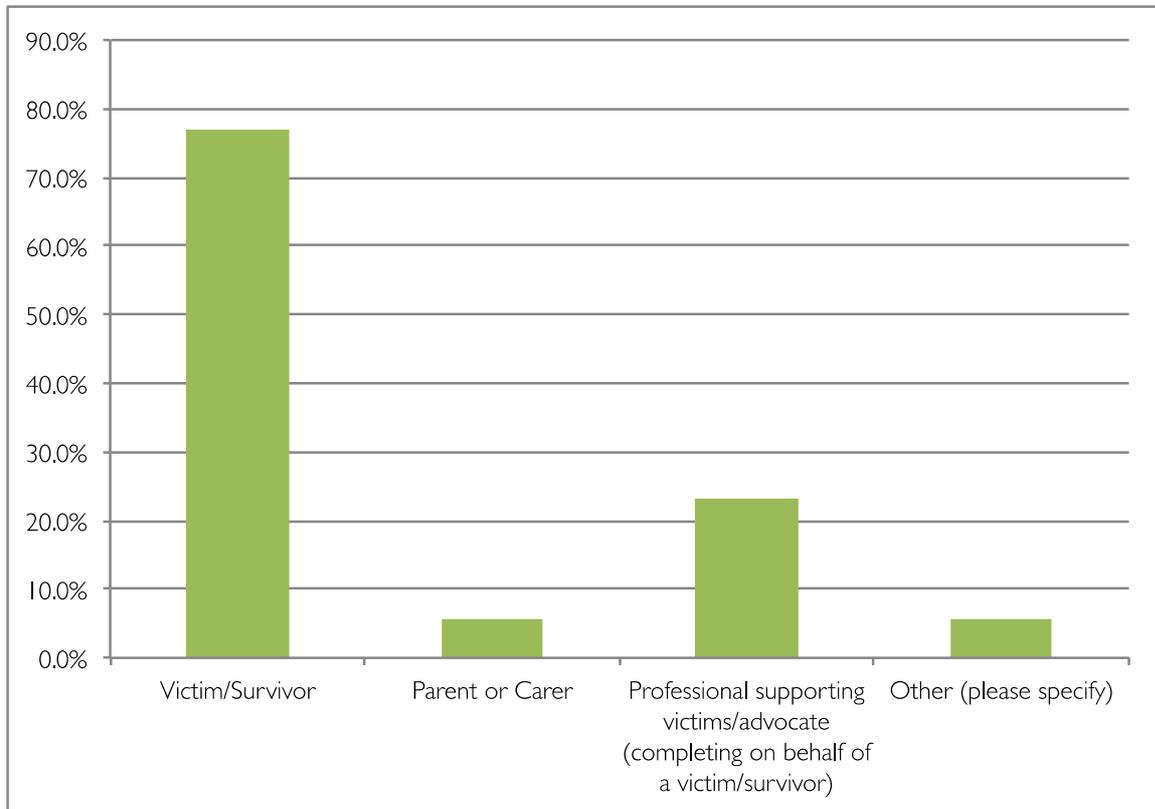


Figure 2 When did the assault /abuse occur ? (n=50)

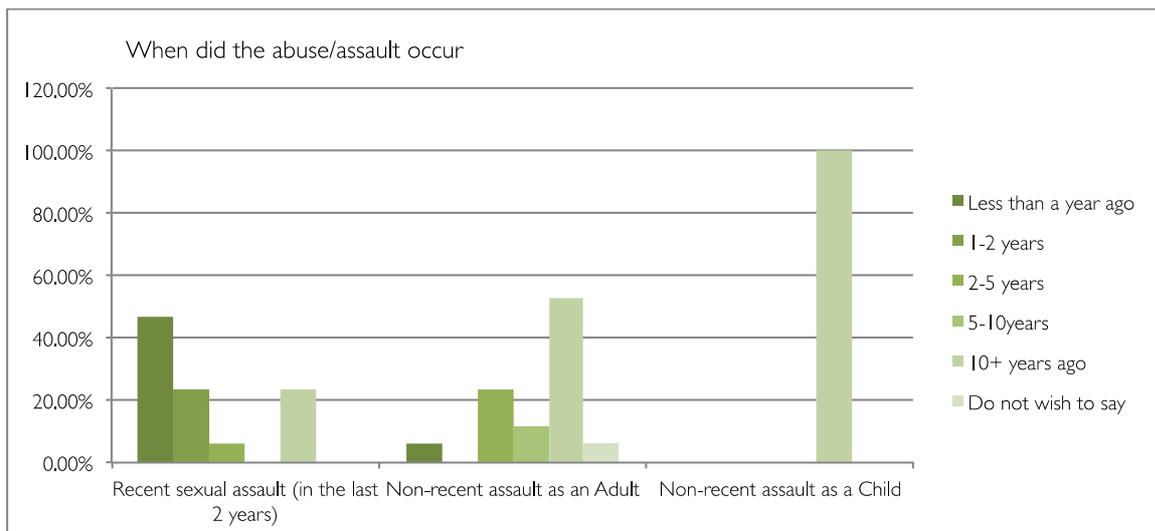


Figure 3 When did you first seek support? (n=50)

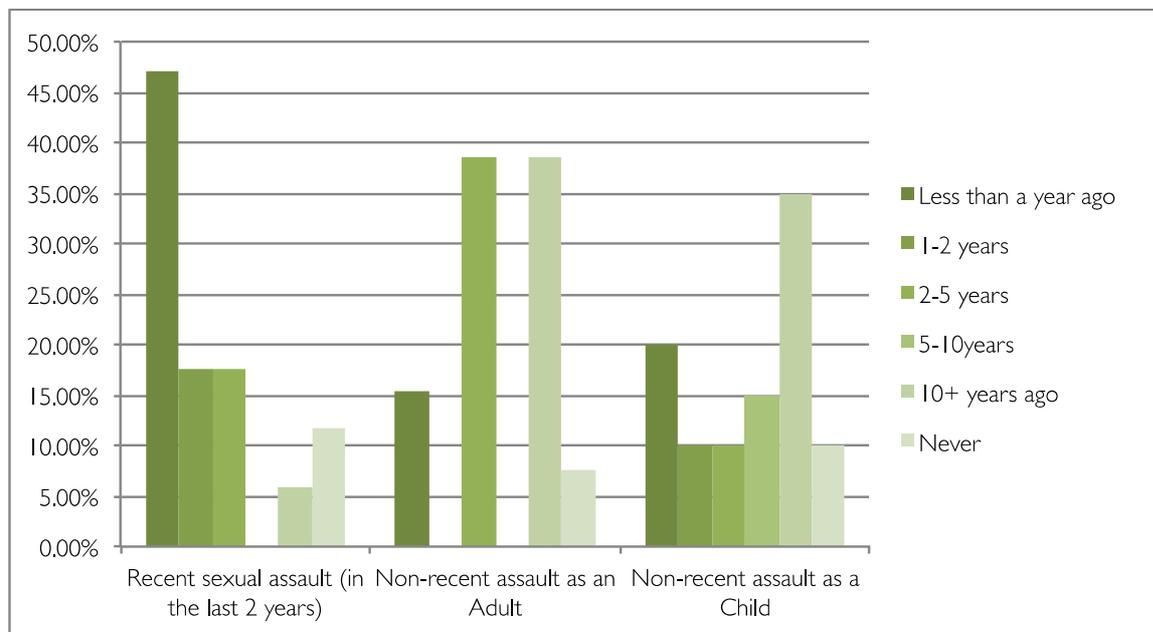


Figure 4 Did you identify as having needs in the following areas related to your experience of sexual violence? (n=50)

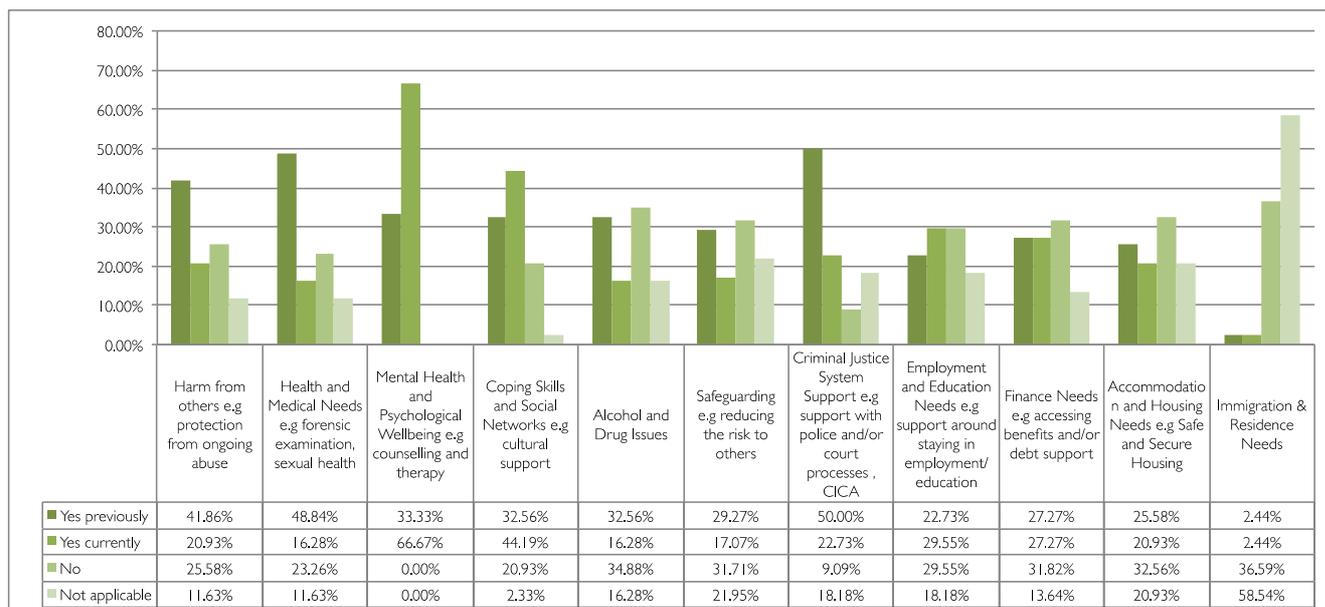


Figure 5 How easily were services able to meet your needs?

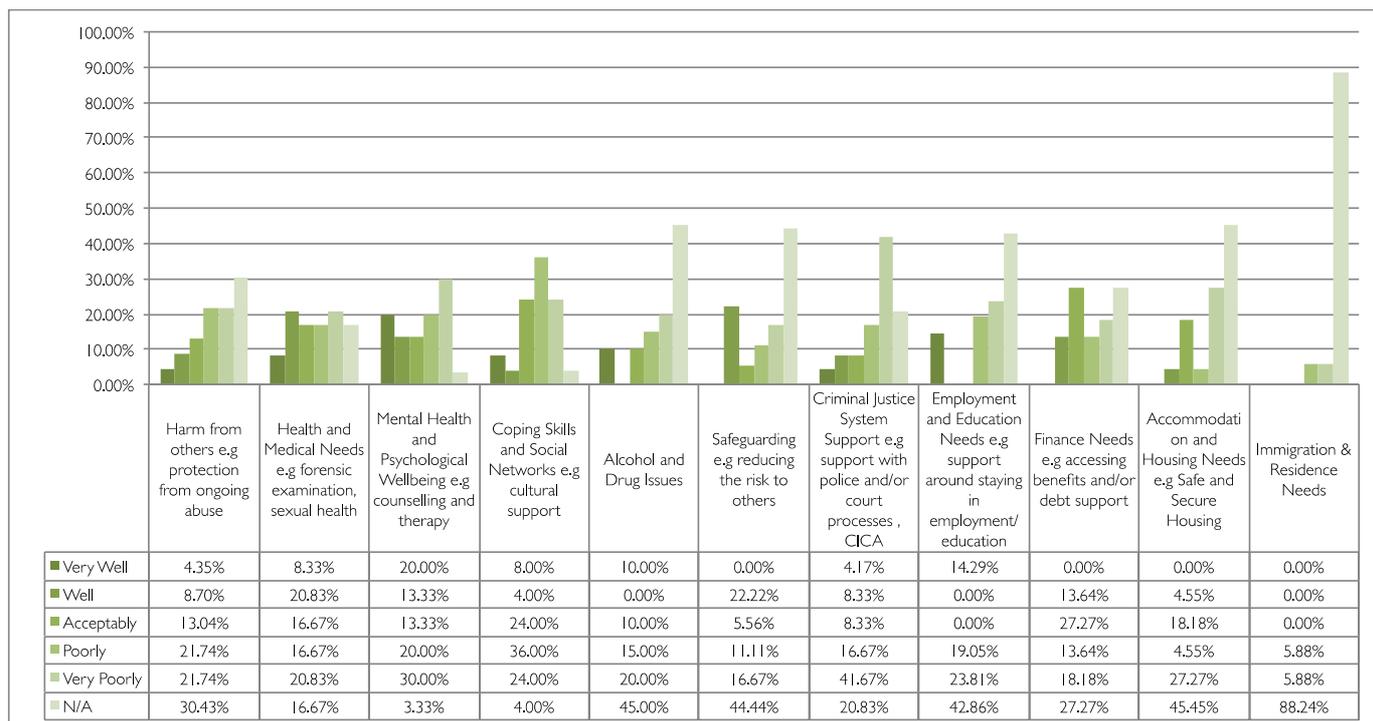
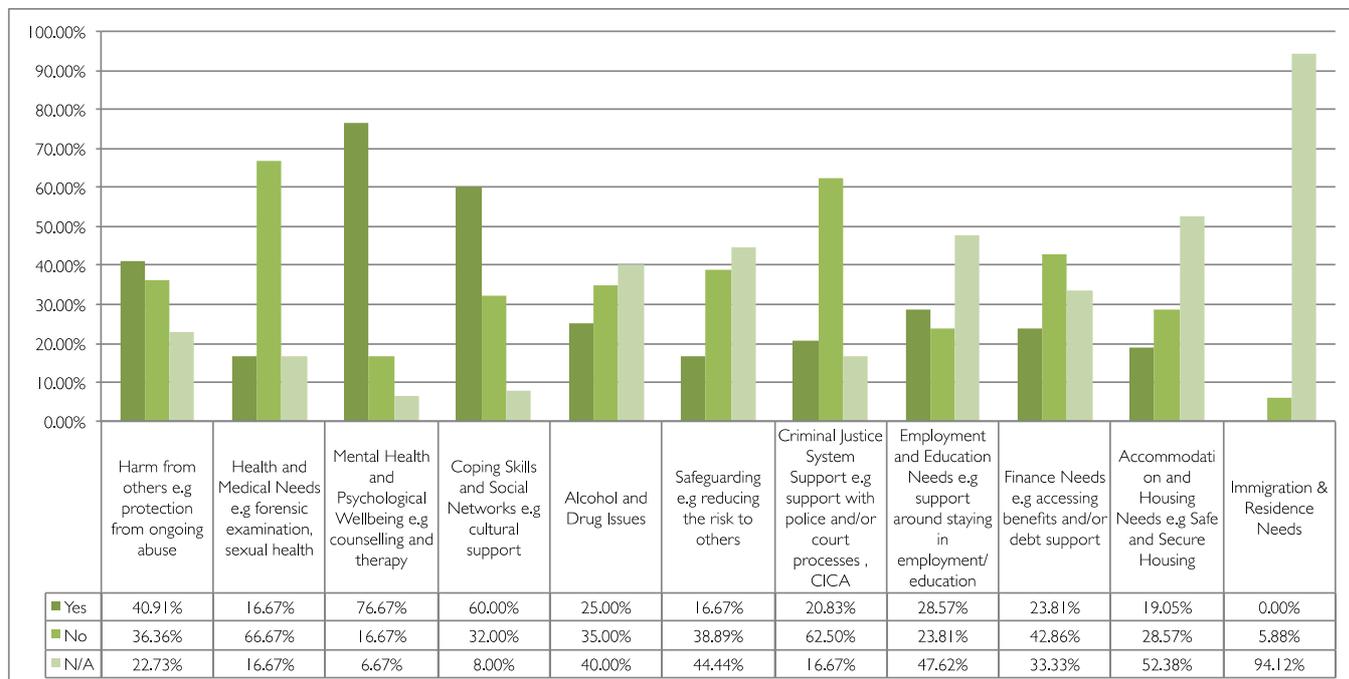


Figure 6 Do you still have needs in these areas?



Demographics of Respondents

Figure 7 Ethnicity of Survey respondents (n=43)

White British	76.7%
White Irish	4.7%
Other White	2.3%
White and Black Caribbean	4.7%
White and Asian	0.0%
Other Mixed Indian	4.7%
Pakistani	2.3%
Caribbean	2.3%
Other Ethnic Group	2.3%

Figure 8 Age of survey respondents (n=45)

0-15	0.00%
16-17	0.00%
18-24	13.33%
25-34	15.56%
34-44	20.00%
45-54	33.33%
55-64	15.56%
75+	2.22%
Prefer not to say	0.00%

Figure 9 Gender Identity of survey respondents (n=45)

Male	20.5%
Female	77.3%
Transgender	0.00%
Other	0.00%
Prefer not to Say	2.27%

Figure 10 Sexuality of Survey Respondents (n=43)

Heterosexual	86.67%
Homosexual	6.67%
Polysexual	2.22%
Prefer not to say	4.44%

Figure 11 Religion of Survey Respondents (n=43)

Christian	24.44%
Buddhist	0.00%
Hindu	2.22%
Jewish	2.22%
Muslim	2.22%
Sikh	0.00%
Other Religion	8.89%
No Religion	55.56%
Prefer not to say	4.44%

Figure 12 Disability of Survey Respondents (n=45)

Physical Disability	3.45%
Learning Disability	3.45%
Autism	6.90%
Mental Health Illness	51.72%
Other Disability	0.00%
Long Term Health Condition	34.48%

What services have people accessed to provide support?

Harm from others e.g protection from on-going abuse

- SSS
- Let's Talk - Nottinghamshire - Insight Notts
- Police
- NSPCC
- University Notts SVSS ISVA
- Women's aid, Police
- CGL

Health and Medical Needs e.g forensic examination sexual health

- GU clinic
- Topaz
- SARC, GUM, GP & Notts SVSS ISVA
- NSVSS
- Topaz Centre (SARC)
- Local GP
- CGL
- Mental health teams

Mental Health and Psychological Wellbeing

- Recovery College NHS
- SHE UK
- SSS
- ISVA
- IAPT
- GP
- Private therapist
- Nottingham Counselling Service..
- NSPCC
- GP
- Mental health team/assessment
- Spec SV Counselling

- Trauma informed person centred long term therapy (third sector)
- Counsellor at university
- Mental Health team
- GP

Coping Skills and Social Network

- Self help group
- SSS
- ISVA
- None
- NSPCC
- Notts SVSS ISVA
- Woman's Centre.
- Counselling
- NHS
- Notts SVSS

Alcohol and Drug Issues

- SSS/ Recovery Network
- ISVA / CGL
- None
- Notts SVSS ISVA SVS & APAS.
- Group work
- N/A
- CGL

Safeguarding and reducing the risk to others

- Equation
- Notts SVSS
- ISVA SSS
- GP
- MASH team.
- Local authority
- CGL

- Local educational providers.
- Job Centre
- Resource Centre
- Working Win (NHS)

Finance Needs

- DWP/SSS
- ISVA
- Notts SVSS ISVA
- Local Council

Criminal Justice System Support

- ISVA
- Police
- Witness Care.
- Witness care
- SVSS
- Topaz
- Notts SVSS
- CGL, Probation

Accommodation and Housing Needs

- Housing
- SSS/ Met Housing
- Notts SVSS
- ISVA Svs
- Housing Aid.
- SSS
- Local Council, CGL

Employment and Education Needs

- SSS
- NSPCC
- Notts SVSS
- ISVA SVS
- Job Centre

Immigration & Residence Needs

- ISVA
- Immigration Advice Service Nottingham
- Local Council

Annex E: Prevalence, Police Reports and Service Demand Data (City/County Split)

The following information provides a breakdown of the estimated prevalence, police reports and service demand split by Nottingham City and Nottinghamshire County.

Prevalence data can be generated by applying the prevalence statistics (Figure 1,4 and 5) shown to the Mid-Year population estimates⁵⁸ which are available by district but for brevity and comparison with Police Reporting and Demand the analysis provided is by City/County Level

The Project Team were advised that police reporting data can be broken down by district if required.

It has not been possible to split the reporting from specialist SV services into County Districts, as the level of data completeness across all services would not support this analysis. The Project Team understands commissioning arrangements since March 2019 should allow data to be reported by district in future analysis.

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<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland>

1. Estimated Prevalence of Sexual Abuse and Assault In Nottinghamshire

1.1 Adults

1.1.1 Proportion of adults experiencing rape or sexual assault in the last year or since the age of 16 from the Crime Survey England and Wales 2018

Figure 1 Prevalence estimates from the Crime Survey England and Wales 2018

	Percentage of population who have experienced rape/sexual assault based on the CSEW ⁵⁹						
		Since the age of 16			In the last year		
		Men	Women	All	Men	Women	All
Sexual assault including attempts	Serious sexual assault	0.5	7.7	4.1	0.1	0.9	0.5
	Rape	0.4	6.9	3.6	0.0	0.7	0.4
	Less serious sexual assault	4.4	23.3	13.8	1.2	3.8	2.5
	Sexual assault by a partner	0.7	6.3	3.5	0.1	0.4	0.2
	Sexual assault by a family member	0.2	1.9	1.0	0.0	0.1	0.1
	Any sexual assault	4.5	24.3	14.4	1.2	4.2	2.7
Sexual assault excluding attempts	Serious sexual assault	0.4	6.3	3.3	0.0	0.7	0.4
	Rape	0.4	5.7	3.0	0.0	0.4	0.2
	Assault by penetration	0.2	4.1	2.1	0.0	0.4	0.2

⁵⁹ Table S34: Prevalence of intimate violence among adults aged 16 to 59, by category, year ending March 2018 CSEW¹
<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwales/appendixtables>

1.1.2 Estimated Numbers of Nottinghamshire Adults who have experienced rape or sexual assault in the last year or since the age of 16.

1.1.2.1 Nottingham City

Figure 2 Estimated number of Adults in Nottingham City who have experienced rape or sexual assault using estimates from the Crime Survey England and Wales 2018⁶⁰ applied to Mid Year Population Estimates for 2018⁶¹

		Estimated numbers of adults who have experienced rape/sexual assault					
Nottingham City		Since the age of 16			In the last year		
		Men	Women	All	Men	Women	All
Sexual assault including attempts	Serious sexual assault	505	8,150	8,655	72	960	1,032
	Rape	442	7,262	7,704	55	712	767
	Less serious sexual assault	4,857	24,533	29,390	1,294	4,041	5,335
	Sexual assault by a partner	779	6,632	7,411	87	382	468
	Sexual assault by a family member	188	1,995	2,184	56	141	197
	Any sexual assault	5,041	25,597	30,638	1,343	4,462	5,804
Sexual assault excluding attempts	Serious sexual assault	440	6,665	7,249	55	694	763
	Rape	416	6,029	6,565	55	467	530
	Assault by penetration	273	4,284	4,645	29	421	458

⁶⁰ Table S34: Prevalence of intimate violence among adults aged 16 to 59, by category, year ending March 2018 CSEW¹

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwales/pendixtables>

⁶¹ ONS Mid Year Population Estimates for 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimateforukenglandandwalesscotlandandnorthernireland>

1.1.2.2 Nottinghamshire County

Figure 3 Estimated numbers of Adults in Nottinghamshire County who have experienced rape or sexual assault using estimates from the Crime Survey England and Wales 2018⁶² applied to Mid Year Population Estimates for 2018.⁶³

		Estimated numbers of Nottinghamshire adults who have experienced rape/sexual assault					
Nottinghamshire County		Since the age of 16			In the last year		
		Men	Women	All	Men	Women	All
Sexual assault including attempts	Serious sexual assault	1025	17619	18,492	146	2075	2203
	Rape	898	15699	16,457	111	1539	1637
	Less serious sexual assault	9857	53035	62,553	2626	8736	11313
	Sexual assault by a partner	1580	14338	15,764	176	825	993
	Sexual assault by a family member	382	4314	4,663	113	306	417
	Any sexual assault	10230	55335	65,168	2724	9645	12305
Sexual assault excluding attempts	Serious sexual assault	892	14409	15,176	111	1500	1598
	Rape	845	13034	13,746	111	1009	1111
	Assault by penetration	554	9262	9,726	58	910	960

1.2.3 Adults experiencing of rape or sexual assault before the age of 16

Figure 4 Estimated Proportion from CSEW⁶⁴ & numbers of adults who have experienced rape or any sexual assault during childhood (using applied to Mid Year Population Estimates for 2018)⁶⁵

	Proportion of Adults who report experience of sexual assault during childhood	Estimated numbers Nottinghamshire adults who have experienced sexual assault during childhood

⁶² Table S34: Prevalence of intimate violence among adults aged 16 to 59, by category, year ending March 2018 CSEW¹

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/sexualoffendingcrimesurveyforenglandandwalesappendixtables>

⁶³ ONS Mid Year Population Estimates for 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimateforukenglandandwalesscotlandandnorthernireland>

⁶⁴ Proportion of adults who experienced sexual assault during childhood by type of sexual assault and personal characteristics, year ending March 2016 CSEW

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/abuseduringchildhood/findingsfromtheyearendingmarch2016crimesurveyforenglandandwales>

⁶⁵ ONS Mid Year Population Estimates for 2018

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimateforukenglandandwalesscotlandandnorthernireland>

Age	Any sexual assault	Sexual assault by rape or penetration (inc attempts)	Other sexual assault	Other sexual assault	Sexual assault by rape or penetration (inc. attempts)	Any sexual assault (inc. attempts)
Nottingham City	6.6%	2%	6.3%	14,311	4,337	13,661
Nottinghamshire County				29,964	9,080	28,602

1.3 Children

1.3.1 Estimated numbers of children in Nottinghamshire who have experienced sexual abuse or assault in the past year

Figure 5 Estimated percentages of children who have experienced sexual abuse or assault in the Past Year⁶⁶

Percentage of Children who have experienced sexual abuse of assault in the Past Year.	Under 11s PY	11–17s PY
Contact Sexual Abuse	0.2%	1.9%
Estimated Any Sexual Abuse (including non-contact)	0.6%	9.4%

1.3.2 Nottingham City

Figure 6 Annual numbers of children In Nottingham City who experience sexual abuse (contact/non-contact) in the using NSPCC estimate ⁶⁷ applied to Mid Year Population Estimates for 2018) ⁶⁸

Nottingham City			
Age	Population	Contact Sexual Abuse	Non-Contact Sexual Abuse
10 and under	44,885	90	539
11-17	20,324	386	1,910
Totals	65,209	476	2,449

1.3.3 Nottinghamshire County

⁶⁶ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

⁶⁷ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

⁶⁸ ONS Mid Year Population Estimates for 2018 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimateforukenglandandwalesscotlandandnorthernireland>

Figure 7 Annual numbers of children In Nottingham City who experience sexual abuse (contact/non-contact) in the using NSPCC estimate ⁶⁹ applied to Mid Year Population Estimates for 2018) ⁷⁰

Nottinghamshire County			
Age	Population	Contact Sexual Abuse	Non-Contact Sexual Abuse
Under 11years	104,284	209	1,251
11-17	53,402	1,015	5,020
Totals	157,686	1,223	6,271

⁶⁹ Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC <https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf>

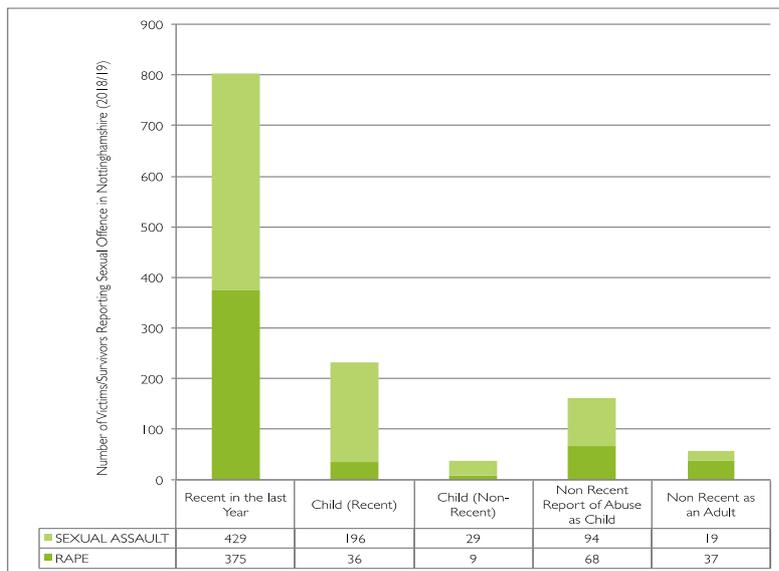
⁷⁰ ONS Mid Year Population Estimates for 2018 <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimateforukenglandandwalesscotlandandnorthernireland>

2. Police Recorded Sexual Offences

2.1 Numbers of Rape of Sexual Assault – Police Reports 2018/19 (Adults and Children)

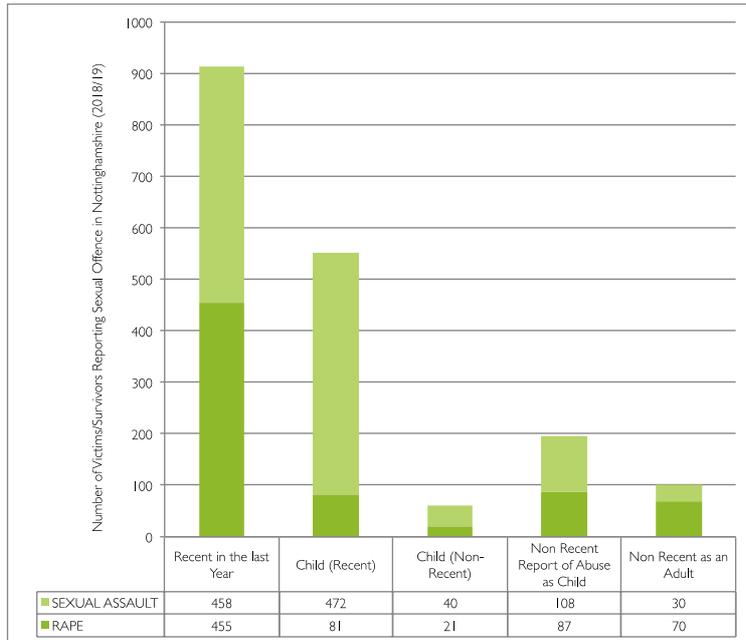
2.1.1 Nottingham City

Figure 8 Graph and table showing the number of police recorded sexual offences against adults and children 2018/19



2.1.2 Nottinghamshire County

Figure 9 Graph and table showing the number of police recorded sexual offences against adults and children 2018/19



3. Demand on Services

3.1 Police Reports and Referrals to SAAS Pathways Services (Adults) 2018/19

Figure 10 Chart showing the number of reports police of sexual abuse/assault and number of referrals made to commissioned SAAS pathways services in 2018/19

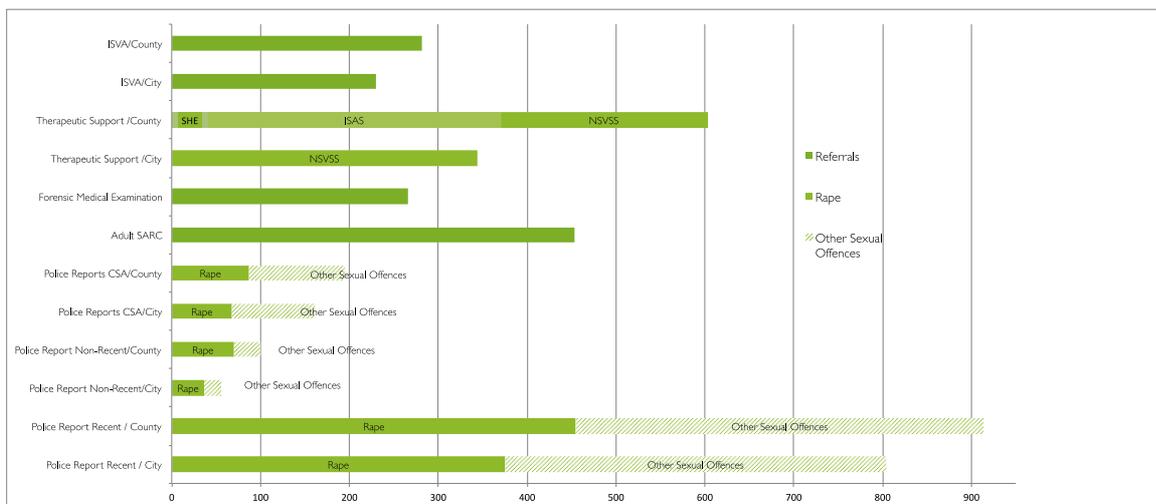


Figure 11 Table showing the number of police recorded sexual offences against adults and referral to SAAS pathway services in 2018/19

Nottinghamshire PFA	City		County	
	Rape	Other Sexual Offences	Rape	Other Sexual Offences
Police Recorded Offences Recent (less than one year after the offence)	375	429	455	458
Police Recorded Offences Non-Recent (more than one year after the offence)	37	19	70	30
Adults reporting experience of Child Sexual Abuse	68	94	87	108
Services				
Adult SARC Referrals			553	
Forensic Medical Examination			266	
Therapeutic Support	344		603	
ISVA	230		282	

N.B some cases have been removed where the City/County identifier was not present in the service data.

3.2 Police Reports and Referrals to SAAS Pathways Services – Children - 2018/19

Figure 12 Chart showing the number of reports police of sexual abuse/assault and number of referrals made to commissioned SAAS pathways services in 2018/19

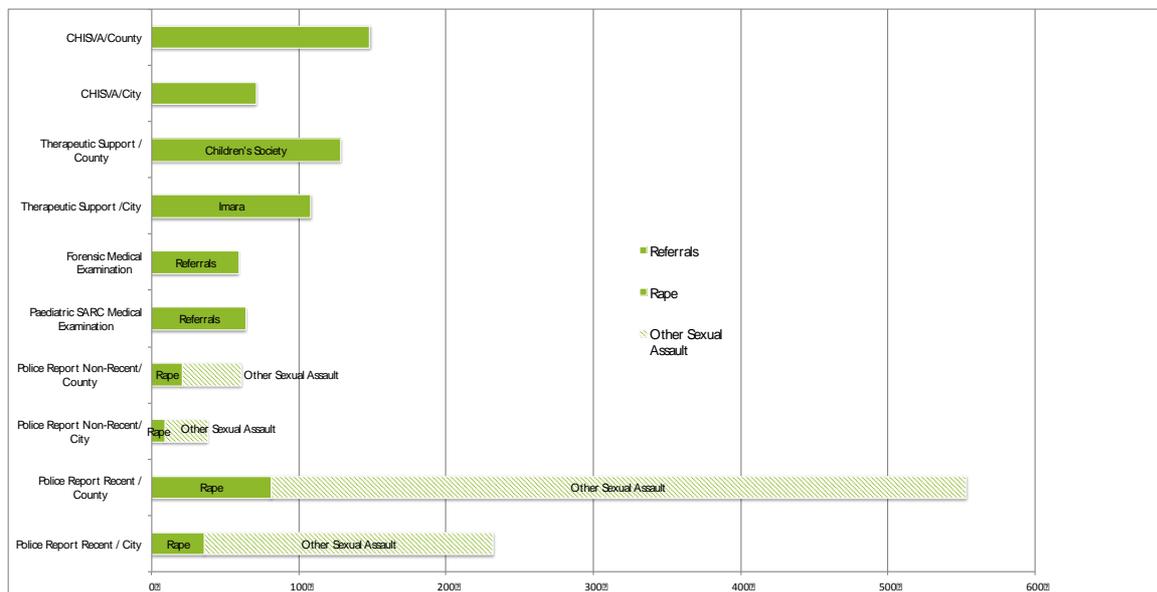


Figure 13 Table showing the number of police recorded sexual offences against children and referrals to SAAS pathway services in 2018/19

Nottinghamshire PFA	City		County	
	Rape	Other Sexual Offences	Rape	Other Sexual Offences
Police Recorded Offences				
Recent (less than one year after the offence)	36	196	81	472
Non-Recent (more than one year after the offence)	9	29	21	40
Services				
Paediatric SARC Medical Examinations	64			
Forensic Medical Examination	59			
Therapeutic Support	103		128	
ISVA	71		148	

The Project Team is aware that some services commissioned for the County/City are for 13+ and 16+ who would also be considered children in Police Reports However these

have been reported within the adult figures as we were not able to break these down within the data received.

Annex F: Therapeutic Evidence Base

Identifying Effective Therapeutic Interventions for victims of sexual violence

'Counselling' and 'psychological therapies' are overarching terms to describe a range of therapeutic modality or therapeutic approach. There are hundreds of different modalities and approaches available, all with differing levels of effectiveness.

The Project Team is aware that specialist sexual violence services working with victims of sexual violence tend to use "trauma-informed" interventions with specific reference to sexual abuse/assault. Trauma focused interventions may be described as aiming to reduce or eliminate the symptoms of trauma, Post Trauma Stress Disorder (PTSD) and anxiety, and normalise the symptoms as a response to an abnormal event. In addition, services will often provide abuse-focused interventions may be described as encouraging the client to express feelings related to the abuse and clarify beliefs about the abuse, such as shame or guilt.

Where there is a diagnosis of post-traumatic stress disorder (PTSD), trauma informed CBT and EMDR are recommended under National Institute of Health and Clinical Excellence (NICE) guidelines⁷¹⁷² and evidenced by a series of systematic reviews. Both of these are trauma-focused psychological treatments that specifically address the PTSD sufferers' troubling memories of the traumatic event and the personal meanings of the event and its consequences. Direct comparisons of these two approaches did not reveal any significant advantages for one over the other, with respect to either treatment outcome or the speed of therapeutic change. The guidance provides further advice on the duration of support and managing the social needs of those experiencing PTSD.

A Rapid Evidence Based Review on "What can be learnt from other jurisdictions about preventing and responding to child sexual abuse" commissioned by IICSA⁷³ highlighted

⁷¹ The guideline does not apply to people whose main problem is the ICD-10 diagnosis of 'Enduring personality changes after catastrophic experience' (F62.0), the concept corresponding to 'Disorders of extreme distress not otherwise specified/complex PTSD' (see definition 2.3.6.1), which may develop after extreme prolonged or repeated trauma, such as repeated childhood sexual abuse or prolonged captivity involving torture. The guideline does not address dissociative disorders, which may develop after traumatic events, or adjustment disorders (F43.2), which may develop after less severe stressors.

⁷² <https://www.nice.org.uk/guidance/cg26>

⁷³ <https://www.iicsa.org.uk/publications/research?page=1>

that the evidence on victim support and recovery focuses mostly on child sexual abuse, while needs of those who have been sexually exploited may differ. Best evidence on therapeutic treatment for children exists for trauma focused CBT although a variety of therapeutic methods, for example those using drama or EMDR, also show promise. Therapy approaches may be more effective when tailored to the individual needs of the child or young person, taking into account their specific symptom constellation, development, context, and background.

The 'Delphi Expert Review: A Consultation' conducted by the Department of Health⁷⁴ and published in 2011 is often referenced by specialist sexual violence services. This was an analysis of professional viewpoints on the treatment and care of people affected by child sexual abuse, domestic violence and abuse, and rape and sexual assault. The research has been criticised as it did not provide any outcomes or efficacy data and relied instead on the views of professionals.

There are no systematic reviews of the evidence of the effectiveness of therapies specifically for victims of sexual violence either for adults or children. It should be noted this should not be interpreted as evidence that specialist therapeutic interventions are ineffective, rather that they may not readily lend themselves to the systematic reviews required for evaluations considered by NICE.

⁷⁴ Itzin, Taket & Barter-Godfrey, 210 Findings from a Delphi Expert Consultation on Therapeutic and Treatment Interventions with victims, survivors and abusers, children, adolescents and adults. <https://www.semanticscholar.org/paper/DOMESTIC-AND-SEXUAL-VIOLENCE-AND-ABUSE%3A-FINDINGS-A-Itzin-Taket/5093309ddb40852d5e05fbad965c7b12ca75fdc5>