



Leicester
City Council



Safer Leicester Partnership
Working together for a safer City

Sexual Violence Needs Assessment

May 2013

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Forward

There have been a number of previous attempts in Leicester to develop a strategic approach to the prevention and response to sexual violence.

This document is a desk top brief assessment of the estimated scale of the issue and the current service provision in place to meet this need. The assessment has been undertaken to support a review of current service provision and to inform the commissioning of a more coherent pathway for victims of sexual violence.

1.0 Introduction

Sexual violence is a complex issue often further compounded by the hidden nature of offending. In 2011/12, 53665 sexual offences were recorded by the police in England and Wales including around 16,000 rapes and 22,000 sexual assaults. Sexual violence is known to be widely under-reported, with only one in ten adult victims of serious sexual assault reporting the incident to police¹

It is estimated that 20% of women and 3% of men have suffered a sexual assault since the age of 16²

Young women are at greatest risk of sexual assault, with just under 8% of 16-19 year olds reporting an attempted or actual sexual assault in the previous year. Other groups also at increased risk include sex workers³ and gay and bisexual men.⁴

Perpetrators of serious sexual assault are most often known to the victim. Over half of female victims in 2009/10 were assaulted by partners or ex partners and a further 29% were known to the victim, with only 14% being assaulted by strangers⁵.

Less serious sexual assaults such as indecent exposure and sexual threats were more likely to be committed by strangers.

Alcohol is a common feature of sexual assault. Over a third of offenders and a quarter of victims of serious sexual assault are thought to have consumed alcohol prior to the incident.

Surveys suggest that there is a negative attitude towards female victims of sexual violence among a sizeable minority of the population, particularly if they have been drinking, using drugs or flirting with the perpetrator prior to the assault.⁶

Sexual violence can also manifest through forced marriage, human trafficking and female genital mutilation (FGM). The extent of all these forms of violence is largely unknown.

2.0 Definition of Domestic and Sexual Violence

Over the last decade the British Crime Survey has increased our understanding of the inter-related nature of sexual violence, domestic abuse and stalking. This

¹ Smith K et al. Homicides, firearm offences and intimate violence 2008/09: supplementary volume 2 to Crime in England and Wales 2009/10. London Home Office 2011

² ONS Crime in England and Wales March 2012

³ Shannon K et al Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. BMJ 2009 (b2939)

⁴ Peterson ZD et al. Prevalence and consequences of adult sexual assault of men: review of empirical findings and state of the literature. Clinical Psychology Review 2011; 31: 1-24

⁵

⁶ Brown J et al. Connections and disconnections: assessing evidence, knowledge and practice in responses to rape. London: Government Equalities Office 2010

increased understanding of the overlap between domestic and sexual Violence is reflected in the Coalition Government's national strategy: Call to End Violence against Women and Girls, and the subsequent action plans.

The national strategy identifies violence against women and girls as a gender based crime which requires a focused and robust cross-government approach underpinned by a single agreed definition. The United Nations (UN) Declaration (1993) defines violence against women as:

'Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.

This is a broad definition and it is therefore useful to clarify what we understand by domestic and sexual violence in a general sense that also acknowledges that men can also be victims.

2.1 Domestic violence is defined as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

This includes issues of concern to Black and Minority Ethnic and Refugee (BMER) Communities such as so called "honour based violence", Female Genital Mutilation (FGM) and forced marriage.

2.2 Sexual Violence is more complex and lacks a Home Office approved definition. The World Health Organisation defines sexual violence as;

*"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, Including but not limited to home and work"*⁷.

For the purposes of this assessment, sexual violence focuses primarily on rape (including attempted rape) and serious sexual assault. Appendix A provides a legal definition.

⁷ World Health Organization., World report on violence and health (Geneva: World Health Organization, 2002), 149

3.0 Impact of sexual violence

The immediate and long-term health implications of sexual violence are devastating. There are direct health consequences in terms of physical injury, sexually transmitted diseases, and in extreme cases death. Mortality can result either from the act of violence itself, or from acts of retribution (e.g. “honour based killings”) or from suicide. There are also contributory factors that impact on long-term health including mental health problems, alcohol misuse, trauma, unwanted pregnancy, abortion, and risky sexual behaviour. Also; obesity and dental neglect, although less recognised, cause potential longer-term health problems which stem from activities such as over eating (as a coping mechanism).

- Psychological effects vary considerably from person to person, and may include;
- Rape trauma syndrome
- Post-traumatic stress disorder
- Depression
- Social phobias (especially in marital or date rape victims)
- Anxiety
- Increased substance use or abuse
- Suicidal behaviour.

In the longer-term, victims may complain of the following:

- Chronic headaches;
- Fatigue;
- Sleep disturbances (i.e. nightmares, flashbacks);
- Recurrent nausea;
- Eating disorders;
- Menstrual pain;
- Sexual difficulties.

Failure to address the victim’s immediate and on-going needs can have a considerable and long-term impact on their emotional well-being and health. It can also cause the victim to disengage from the criminal justice process, reducing the opportunity for offenders to be brought to justice. Alcohol and drug abuse can be used as a coping mechanism in response to sexual violence. One study highlighted that 67-90% of women with alcohol and drug addiction problems were survivors of sexual abuse⁸.

The wider effects of sexual violence and abuse may be seen in the impact upon victims’ families and community fear of crime: women are more worried about rape than any other crime. There is a burden to society from lost output and the long-term health issues faced by victims and the costs associated with these fall mainly on the NHS. Sexual offences make up 23% of the estimated total cost of crime against individuals and households, the physical and emotional impact being the most costly. Each adult rape is estimated to cost over £76,000 in its emotional and physical

⁸ Wilson, J (1998) Dual diagnosis: addiction and childhood sexual abuse. Addiction Counselling World: May / June 1998 (8(52)): 14-16

impact on the victim, lost economic output due to convalescence, early treatment costs to the health service and costs incurred in the criminal justice system⁹. The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion. Addressing the needs of victims early through the provision of Sexual Assault Referral Centres (SARCs) can reduce these costs and deliver benefits to victims in terms of better health, wellbeing and quality of life as well as long term productivity savings in services if the immediate aftermath of sexual assault is managed effectively.

4.0 Risk Factors associated with Sexual Violence

A risk factor is an attribute, characteristic or exposure that increases the likelihood of an event. There are a number of factors that are commonly associated with an increased risk of sexual assault occurring. Research suggests that these factors have an additive effect, i.e. the more factors present the greater the likelihood of sexual violence occurring.

Risk Factors for being a victim of sexual violence

- Being young
- History of sexual assault when young
- Deprivation – poverty
- Being married or cohabiting
- Alcohol and drug consumption
- Being a sex worker
- Mental illness
- Learning and/or physical disability

Risk factors for committing sexual violence

- History of child sex abuse
- Poverty – income inequality
- Social norms- male entitlement
- Alcohol and drug consumption

5.0 Sexual Violence in Leicester

5.1 Nationally collected data

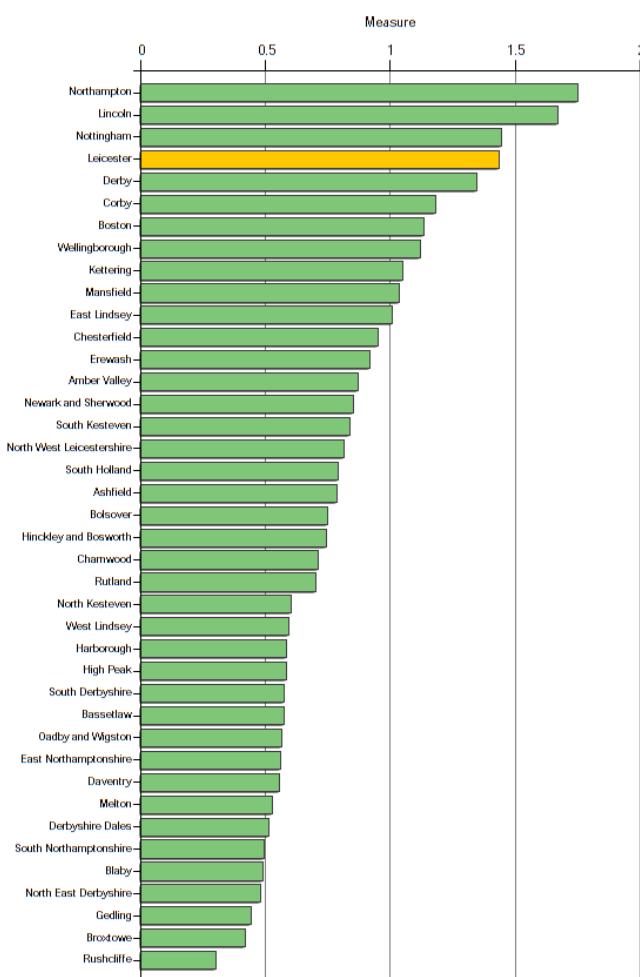
5.1.1 VIPER Data

Data collected as part of the national Violence Indicator Profiles in the English Regions (VIPER) data set indicate that the 2011/12 crude rate of recorded sexual offences (1.4 per 1,000 population) for Leicester City is the fourth highest in the East Midlands (see graph 1).

The number of sexual offences recorded in Leicester during 2011/12 was 441

⁹ Home Office. The economic and social costs of crime against individuals and households 2003/4: Home Office Online Report 30/05, 2005.

Figure 1 Sexual offences, crude rate per 1,000 population, 2011/12 (Home Office recorded crime statistics and Office for National Statistics 2010 mid-year population estimates rounded).



5.1.2 British crime survey

The British Crime Survey (BCS) is a systematic victim study, carried out on behalf of the Home Office. The BCS seeks to measure the amount of crime in England and Wales by asking around 50,000 people aged 10 and over, living in private households, about the crimes they have experienced in the last year.

The BCS may provide a better reflection of the true level of crime than police statistics alone since it includes crimes that have not been reported to, or recorded by, the police.

The BCS also provides a better measure of trends over time since it has adopted a consistent methodology and is unaffected by changes in reporting or recording practices.

The BCS has weaknesses as it has five crimes per person cap, which may not take into account long-term abuse such as domestic violence. It also excludes residents of communal establishments such as hostels, nursing and care homes and university halls of residence.

Due to sensitivity of reporting in the context of a face-to-face interview, the main BCS crime count does not include rape and other sexual offences. However, it does provide estimates of the proportion of adults (aged 16-59) who have been a victim of such offences, which are obtained through a supplementary set of questions answered by self-completion outside the main interview. For 2011/12 the survey shows that approximately three per cent of women aged 16 to 59 and less than one per cent of men (of the same age) had experienced a sexual assault (including attempts) in the previous 12 months. The majority of these are accounted for by less serious sexual assaults.

Applying the BCS figures to the Leicester population (aged 16-59) it is possible to estimate the number of sexual offences that may be occurring within the population.

Figure 2 Prevalence of intimate violence in the past year (2011/12) for men and women (aged 16-59) by category based on the British Crime Survey

Category of Sexual offence	Respondents from BCS (% victims in past year 2011/12)	Estimated number for Leicester City (based on 2010 mid-year population estimates)
Any sexual assault (including Attempts)	1.6	3173
Serious sexual assault (including attempts)	0.3	595
Serious sexual assault	0.2	397
Rape (including attempts)	0.2	397
Rape	0.2	397
Assault by penetration (including attempts)	0.2	397
Assault by penetration	0.1	198
Less serious sexual assault	1.5	2975

5.2 Locally collected data

5.2.1 Signal Data

Signal is the specialist rape investigation unit for Leicester, Leicestershire and Rutland.

Between 1 April 2012 and 3 March 2013, Signal received 440 referrals for a variety of incidents and crimes including some from out of county.

There appears to be an increase in the number of offences compared to the previous year, which may be due to a number of factors including increased confidence in reporting and more robust recording of incidents.

Offences are categorised by the relationship between the offender and the victim.

The offences were analysed and categorised using the following criteria:

Intimate: Partner (current or ex)/Family

Acquaintance: Direct (known by the victim)/Indirect (known by an acquaintance or family member of the victim)/Prior (some minor prior contact before the offence date but not a direct acquaintance)

Stranger: Not known in any way by the victim/Prior (some minor contact on the offence date)/Street worker

Figure 3 Signal data victim relationship to perpetrator

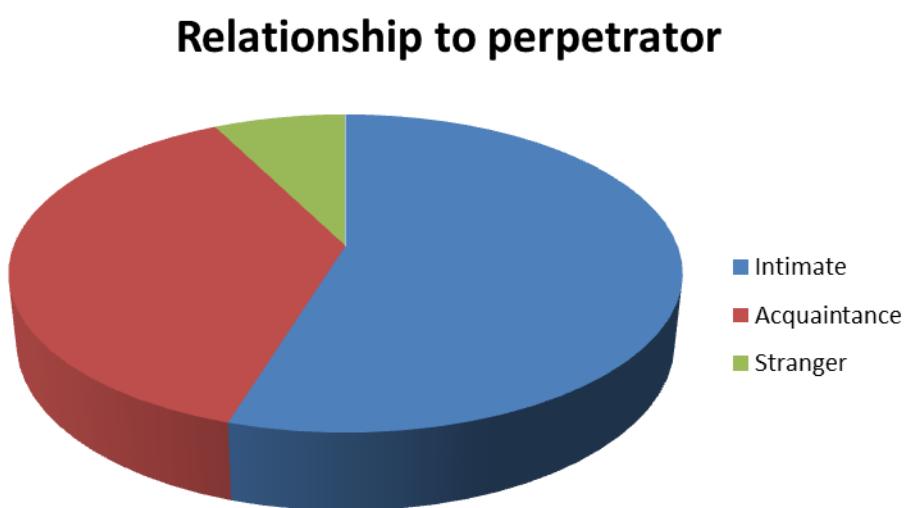


Figure 4 signal data ethnicity of victim

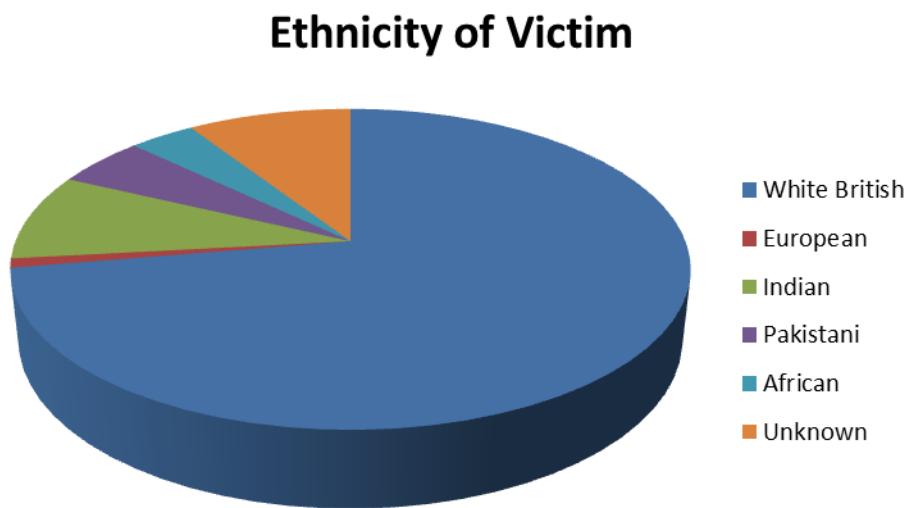
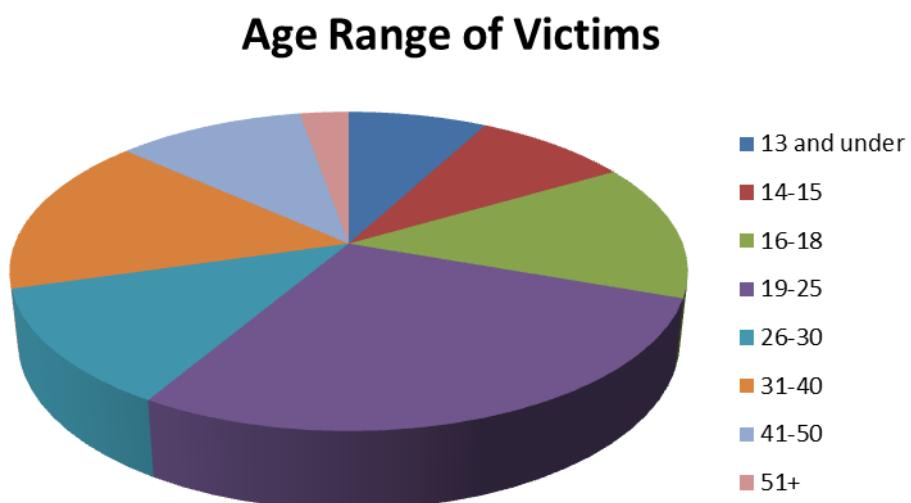


Figure 5 Signal data age of victims



5.2.2 Juniper Lodge Data

Juniper Lodge is a sexual assault referral centre providing multi-agency support to survivors of rape and sexual assault aged 13 and over including men and women who do not want police involvement. The SARC covers Leicester, Leicestershire and Rutland. The centre receives on average 124 referrals each quarter. The majority of clients are female as illustrated in the graph below.

Figure 6 Gender of clients accessing Juniper Lodge April 2012 – February 2013

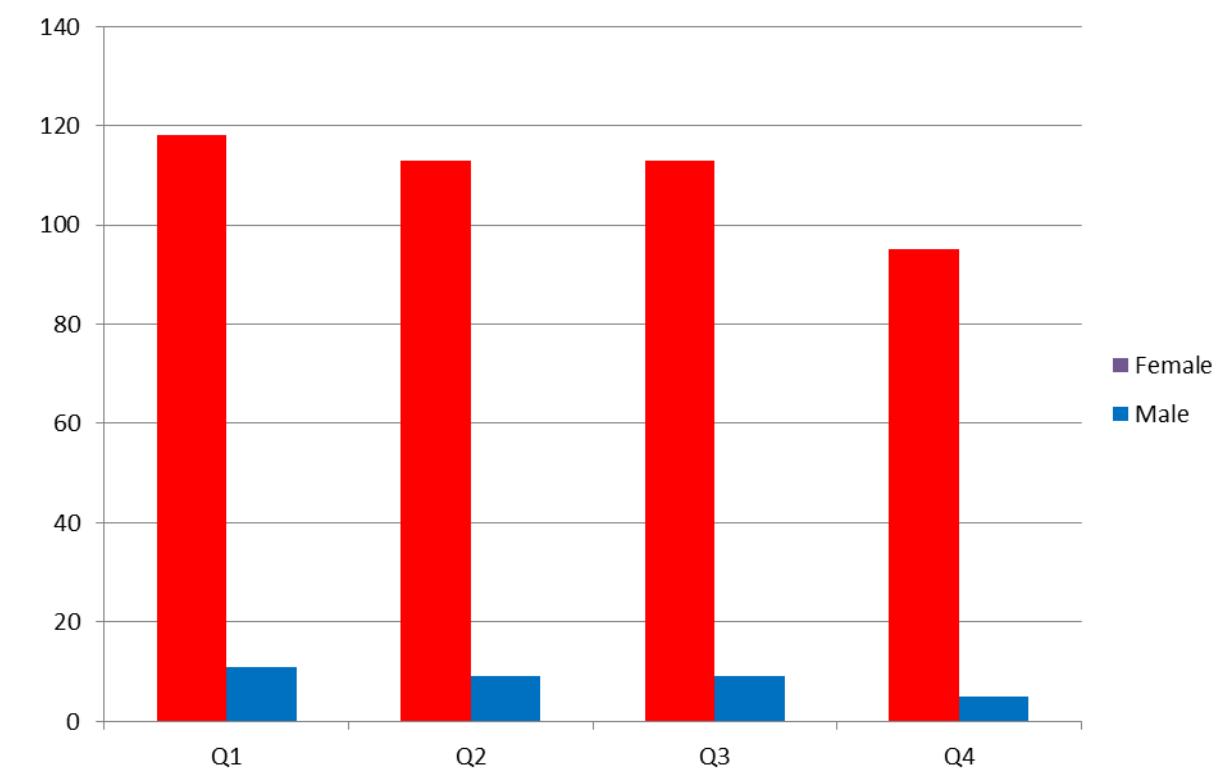


Figure 7 age range of clients referred to Juniper Lodge between April 2012 and February 2013.

Age	First Quarter	Second Quarter	Third Quarter	Last Quarter	Total
13 – 16	15	23	16	12	66 (14%)
17 – 24	46	36	42	29	153 (32%)
25 – 45	46	43	41	39	169(36%)
46+	14	13	12	8	47 (10%)
Not Known	8	7	11	12	38 (8%)
	129	122	122	100	473

The ethnic breakdown, and area of residence of clients referred to Juniper Lodge between April 2012 and February 2013 is illustrated in the charts below

Figure 8 Ethnicity of clients referred to Juniper Lodge

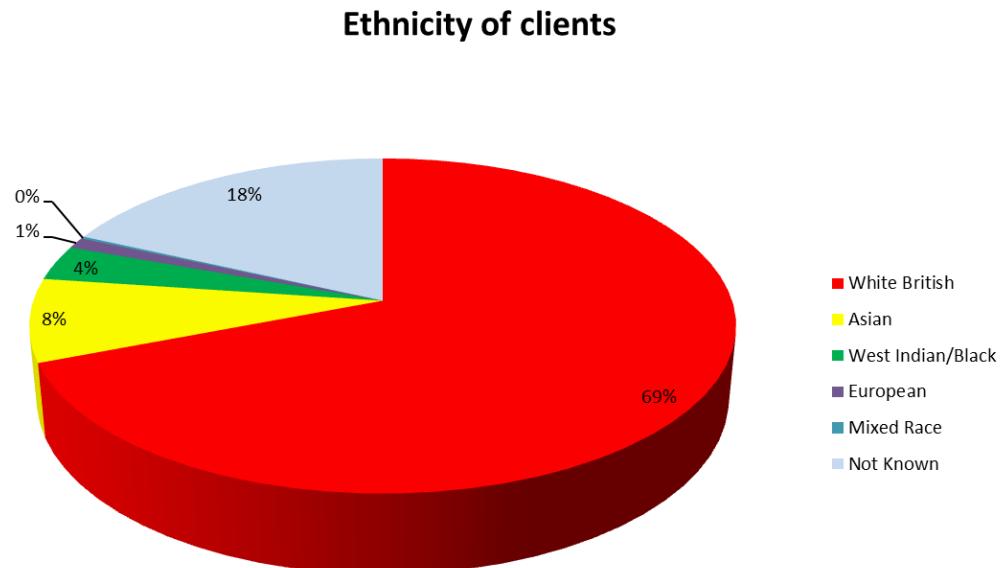
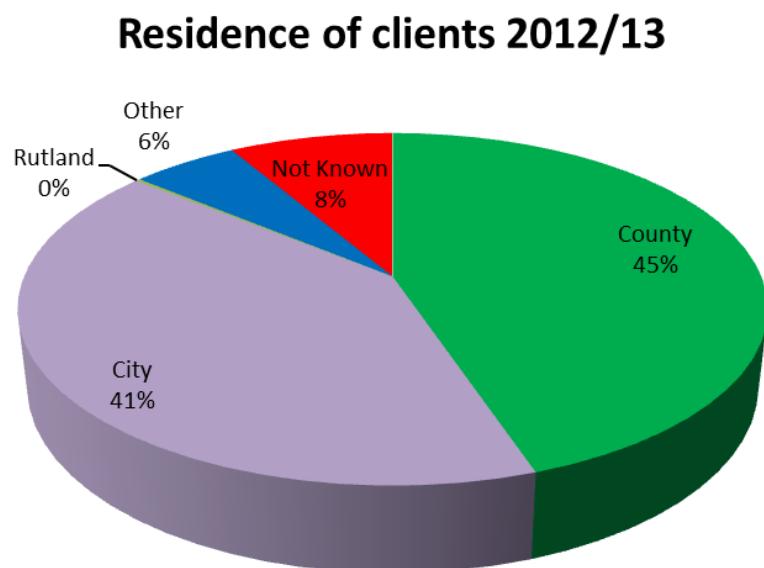


Figure 9 residence of clients referred to Juniper Lodge



Juniper lodge accepts referrals from a wide range of sources including self-referrals, the majority of clients are referred by the police.

Figure 10 Source of referral of clients to Juniper Lodge

Referral source	Number	%
Police	380	80%
Self	32	7%
Mental Health	4	1%
Child and adolescent mental health services (CAMHS)	5	1%
GP	18	4%
Genito-urinary medicine (GUM)	2	0.4%
Domestic Violence Integrated Response Project (DVIRP)	1	0.2%
New Futures	1	0.2%
Drug Worker	2	0.4%
Website	9	2%
School Nurse	2	0.4%
Rape Crisis	1	0.2%
Bethany Project	2	0.4%
Psychotherapist	2	0.4%
School/College	2	0.4%
Independent Sexual Violence Advisor (ISVA)	1	0.2%
Supported Housing	1	0.2%
Other Force	1	0.2%
Other Sexual Assault Referral Centre (SARC)	2	0.4%
Other	7	1.5%

5.2.3 First Step Data

First step is an organisation providing free confidential services to male survivors of sexual abuse and their supporters living in the city of Leicester, Leicestershire and Rutland

In the 20012/13 the service saw 53 male clients and 1 transgender client. The majority of clients (83%) were white British, 13% of clients were Asian 2% were African/Caribbean and 2% were European

The peak age range of clients was the 26-30 age group

50% of clients were resident in the city and 50% resident in the county

Figure 11 source of referral of clients to First Step

Referral source	Number	%*
Police	2	4%
Self	13	24%
Mental Health	5	9%
Probation	3	6%
GP	8	15%
Independent Sexual Violence Advisor (ISVA)	3	6%
Drug /Alcohol Team	2	4%
Homeless Services	2	4%
Other counselling organisations	7	13%
Victim Support	2	4%
Quality of Life	1	2%
SARC	6	11%

*rounded up figures

5.2.4 Women's Aid/ Rape Crisis (County ISVA) Data

The table below shows the number of Service Users who have been supported by Women's Aid between 1 April 2012 and 31 December 2012. The table also highlights the number of cases closed. By the end of December 2012, Women's Aid were supporting 31 clients.

Figure 12 Numbers of Services users supported through County ISVA service

	First Quarter	Second Quarter	Third Quarter
Number of Service users Brought Forward From Previous Quarter	35	49	25
Number of New Service Users	18	16	13
Number of Cases Closed	4	40	7
Current Number of Clients Being Supported	49	25	31

The majority of clients of this service are female. 87% of clients were white British, 4% were Asian, and 9% opted not to disclose their ethnicity

The age range of clients and any recorded disability are shown in the tables below

Figure 13 Age range of clients accessing County ISVA service

Age range	Number	%
16-17	2	4%
18-24	10	21%
25-30	9	19%
31-40	15	32%
41-50	7	15%
51-60	3	6%
61+	0	
unknown	1	2%

Figure 14 Clients accessing county ISVA service – disability profile

Disability*	
None	11
Learning Difficulties	4
Physical	1
Mental Health	26
Not Known/ Not Disclosed	6

* Some clients present with more than one category of disability, hence the statistics being higher than the number of clients.

5.2.5 Domestic Violence Integrated Response Project (DVIRP) (City ISVA) Data

Between April 2012 and March 2013 there were 75 new referrals to the service. The majority of clients were female.

Two service users disclosed a disability

The recorded sexual orientation of service users was 62 heterosexual, 1 gay, 1 not disclosed.

The following charts illustrate the ethnicity, and age range of clients accessing the service

Figure 15 Ethnicity of clients accessing City ISVA service

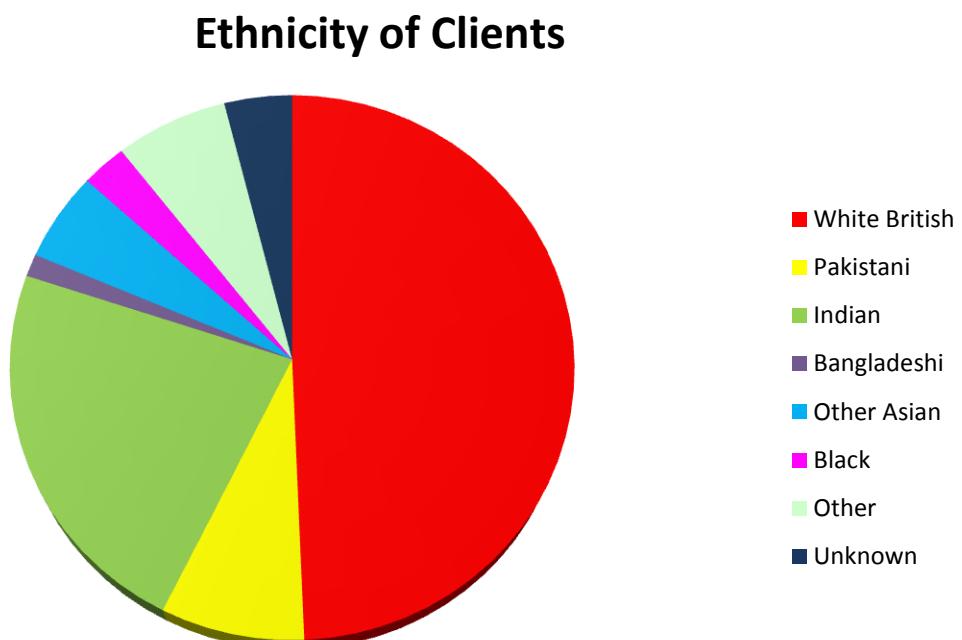
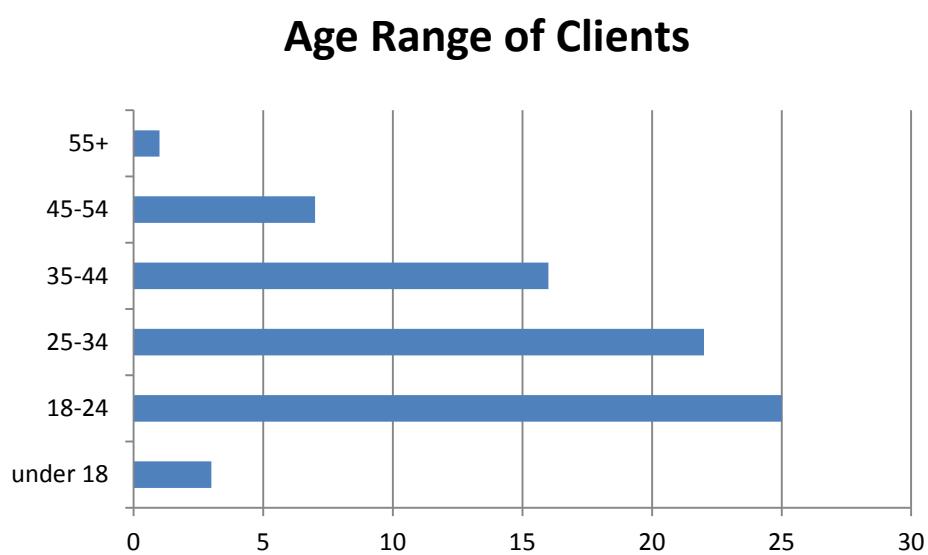


Figure 16 Age range of clients accessing City ISVA Service



The chart below illustrates the relationship between victim and perpetrator

Figure 17 City ISVA clients relationship with perpetrator

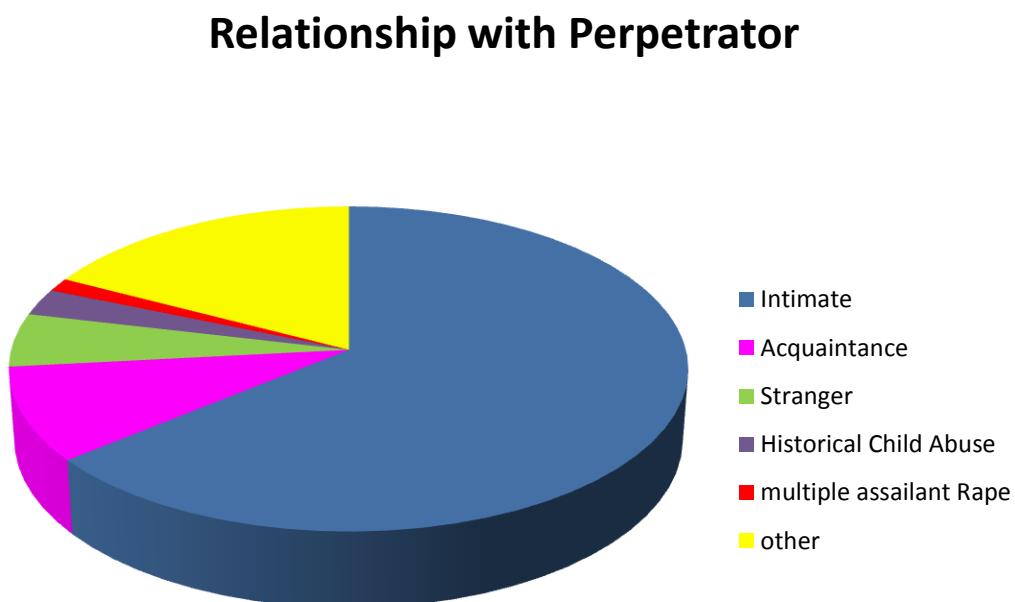


Figure 18 City ISVA Clients Source of referral

Source of referral	Number
Juniper Lodge	32
IDVA	12
SAFE project	7
DV Helpline	7
Just Women	3
Rape Crisis	7
Refuge	2
Leicester Royal Infirmary	1
Self-Referral	2
Probation Service	1
Other	1

5.2.6 Jasmine House (Leicester Rape Crisis)

Jasmine House provides free confidential support and information for women and girls who have experienced any form of sexual violence at any time in their lives. In the year April 2012 to March 2013, Jasmine House saw 196 clients.

5.2.7 The Quetzal Project

The project supports women across Leicestershire and Rutland recovering from the trauma of childhood sexual abuse. The service offers counselling and a helpline.

In 2012/13 The service provided 403 hours of face to face counselling, 480 hours of helpline provision and 85 women received counselling.

5.2.8 Consultation with stakeholders

A series of consultation events were held with current providers of services and other key stakeholders. These events highlighted the following issues with regard to the current provision and commissioning arrangements.

- The local evidence base in terms of prevalence, need and outcomes is not robust
- A more strategic approach to commissioning and provision of sexual violence services is required in order to deliver a clearly defined pathway for victims
- A partnership approach would enable a more coherent and inclusive service provision that meets the needs of the wide range of victims of sexual violence
- A clear and consistent outcomes framework including quality assurance would enable more robust evaluation of the effectiveness of services

5.2.8 Summary of Local Data

Comparison of locally recorded data of estimated numbers suggests that rape and other forms of sexual violence is under reported in Leicester. The total number of sexual offences recorded in Leicester in 2011/12 was 441. Of this number approximately 180 were seen at the SARC (Juniper Lodge). Estimates suggest that the likely figure lies between 379 (rapes) and 3173 (all sexual assaults). There is potential for approximately 200 unreported rapes/serious sexual assaults and 2732 sexual assaults across the city.

Differences in how data is collected across the various services make it difficult to calculate the total number of clients accessing services. The confidential nature of the services provided means that it is difficult to establish whether the clients seen at the various services are all unique i.e. we cannot establish whether some clients are receiving support from more than one source.

6.0 National Guidance

6.1 Sexual Assault Referral Centre Standards¹⁰

Where possible and practical, victims of sexual assault and rape should be assessed in a Sexual Assault Referral Centre (SARC). A SARC is a one-stop location where victims of sexual assault can receive medical care, psychological counselling, legal advice and other support, all in one place from professionally trained staff. They bring together all of the different legal and medical agencies and departments in one place, which helps both the victims and those investigating the crimes. Victims can choose to be dealt with anonymously if they do not wish any involvement from the police.

The term 'SARC' does not just refer to a building, but embraces a concept of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. The Revised National Service Guide⁴⁸ highlights the minimum elements essential for providing high-quality SARCs for victims of sexual violence and sexual abuse, including forensic medical examination. These are;

1. Twenty-four hour access including arrangements for self-referrals, to crisis support, first aid, safeguarding, and specialist clinical and forensic care in a secure unit.
2. Crisis Workers Appropriately trained to provide immediate support to the victim and significant others where relevant, throughout the examination process.
3. Choice of gender of physician wherever possible
4. Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations of adults and children.
5. Dedicated, forensically approved premises
6. The medical consultation includes a risk assessment of harm/self-harm together with an assessment of vulnerability and sexual health; immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.
7. Access to an independent sexual violence adviser (ISVA) to provide support, advocacy and follow-up including support throughout the criminal justice process, should the victim choose that route.

¹⁰ Department of Health, Home Office, Association of Chief Police Officers. Revised National Service Guide – A Resource for Developing Sexual Assault Referral Centres. 2009
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570

8. Well co-ordinated interagency arrangements involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering agreed care pathways and standards of care.
9. The SARC has a core team to provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.
10. A minimum dataset and appropriate data collection procedures in each SARC

6.2 The College of Emergency Medicine Recommendations¹¹

The college of emergency medicine has issued guidelines regarding the management of adult Patients who attend emergency departments after sexual assault and / or rape

Summary of recommendations

1. Where possible and practical, victims of sexual assault and rape should be assessed in a Sexual Assault Referral Centre. Level 5 evidence Strong recommendation.
2. Any forensic examination should only be performed by a clinician with suitable specialist training in an appropriate environment. Level 5 evidence Strong recommendation.
3. Person identifiable information about sexual assaults and rapes should not normally be shared without consent, except in exceptional circumstances. Level 5 evidence Strong recommendation.
4. Emergency contraception should be available to victims attending the emergency department. Level 5 evidence Strong recommendation.
5. There is no requirement for emergency physicians to take pre-transfusion blood samples for the police. Level 5 evidence Strong recommendation.
6. Post exposure prophylaxis for sexually transmitted infections should be available to victims attending the emergency department. Level 2 evidence Strong recommendation.

¹¹ June 2011 The College of Emergency Medicine CLINICAL EFFECTIVENESS COMMITTEE Management of Adult Patients who attend Emergency Departments after Sexual Assault and / or Rape

7.0 Evidence of what works

Primary prevention of sexual violence is often marginalized in favour of providing services for survivors. In order to achieve both improved outcomes for victims and a reduction in the incidence of sexual violence a more holistic approach to service provision is required.

7.1 Prevention

Primary prevention of sexual violence can occur at the individual, community or societal level and be delivered in wide variety of settings. Initiatives can range from awareness raising, addressing issues of gender equality, challenging attitudes and behaviours, addressing the underlying socioeconomic factors linked with violence, encouraging positive parenting and promoting more gender equitable notions of masculinity.

A variety of initiatives to prevent and reduce sexual violence have been trialled in the UK and elsewhere. Programmes which have shown good evidence of effectiveness include education programmes aimed at young people promoting healthy relationships. For example, the Safe Dates programme in the USA targets 12-18 year olds and aims to develop relationship skills (e.g. conflict resolution), address social norms (e.g. dating violence, gender stereotypes) and raise awareness of support services for those affected by violence. It has been found to reduce perpetration of sexual, physical and psychological violence against dating partners, with some benefits also seen in reducing victimisation¹².

There is some evidence for programmes which develop safety skills in young children (e.g. the ability to recognise, and strategies to avoid harmful situations). Programmes which challenge social norms and rape supportive attitudes have been shown to have some success in changing attitudes and behaviours.

It has been postulated that restricting the availability of alcohol may have an impact on levels of sexual violence this is based on the evidence of a link between alcohol restriction and levels of intimate partner violence and child maltreatment.

The effectiveness of mass media campaigns aimed at raising awareness of sexual violence and its implications are difficult to evaluate. However such campaigns do encourage discussion and debate acting as a catalyst for other prevention initiatives¹³.

Psychological and pharmacological treatment of offenders has been shown to be effective in reducing reoffending rates.

¹² Foshee VA, Bauman KE, Ennett ST, et al. Assessing the effects of the dating violence prevention program "safe dates" using random coefficient regression modeling. *Prevention Science* 2005;6:245-58.

¹³ Wellings K, Macdowal W. Evaluating mass media approaches to health promotion: a review of methods. *Health Education* 2000;100:23-32.

7.2 Management of Victims

Psychological treatments aim to address the emotional and mental health problems that result from violence. For example, early trauma-focused cognitive behavioural therapy can prevent chronic post-traumatic stress disorder (PTSD), and has been found to be more effective than other types of counselling¹⁴¹⁵. Psychotherapy can also improve mental health among adults and children who have suffered childhood sexual abuse.

Psychological care and support, counselling, therapy and support group initiatives have been found to be helpful following sexual assaults, especially where there may be complicating factors related to the violence itself or the process of recovery. There is some evidence that a brief cognitive-behavioural programme administered shortly after assault can hasten the rate of improvement of psychological damage arising from trauma. Short-term counselling and treatment programmes after acts of sexual violence, though, require considerable further evaluation. Formal psychological support for those experiencing sexual violence has been provided largely by the non-governmental sector, particularly rape crisis centres and various women's organizations.

Sensitive management of victims and successful prosecution of perpetrators are important factors in encouraging victims of sexual violence to report the offence to the police. The use of standard protocols and guidelines can significantly improve the quality of treatment and psychological support of victims, as well as the evidence that is collected. The preferred model in England is for victims of sexual violence to be managed through a sexual assault referral centre (SARC). A SARC service provides around the clock access to health care and access to forensic recovery (of evidence) and the criminal justice system. SARCs screen for sexually transmitted infections and HIV, provide emergency contraception, forensic recovery and follow-up with onward referrals to other health, care and specialist sexual violence voluntary sector services, including counselling and support. After attending a SARC, clients are assigned an independent sexual violence adviser (ISVA) who provides on-going advocacy and support to access services and help them progress through the criminal justice system, should they choose to do so. While the impact of SARCs on sexual assault victims' outcomes has yet to be robustly studied, other models of specialist sexual assault care have shown benefits. A review of sexual assault nurse examiner programmes that provide specialist medical care and on-going support to victims found they could be psychologically beneficial, offer comprehensive medical

¹⁴ Roberts NP, Kitchiner NJ, Kenardy J, et al. Systematic review and meta-analysis of multiple-session early interventions following traumatic events. *The American Journal of Psychiatry* 2009;166:293-301.

¹⁵ Kornor H, Winje D, Ekeberg O, et al. Early trauma focused cognitive-behavioural therapy to prevent chronic post-traumatic stress disorder and related symptoms: a systematic review and meta-analysis. *BMC Psychiatry* 2008;8:81.

care, obtain forensic evidence correctly and accurately, and facilitate the prosecution of rape¹⁶.

7.3 Training of frontline staff

Training should be provided for front line health and social care staff to ensure greater knowledge and awareness of sexual violence and make them more able to detect and handle cases of abuse in a sensitive but effective way. Such training may also help reduce instances of sexual abuse within the health and social care sector, something that can be a significant, though generally unacknowledged, problem.

8.0 Recommendations for commissioners

- I. A multi-agency strategic response to sexual violence which addresses awareness, prevention and service provision should be undertaken
- II. Work should be undertaken to raise awareness of, and improve signposting to, appropriate services for victims of sexual violence
- III. Extend the provision of emotional support, advice and information to individuals who have experienced rape or sexual assault
- IV. Introduce provision of therapeutic services aimed at individuals who have experienced rape or sexual assault
- V. The local authority should take a lead in the formal commissioning of a sexual violence pathway which ensures equity of provision across protected groups

¹⁶ Campbell R, Patterson D, Lichty LF. The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes. *Trauma, Violence, & Abuse* 2005;6:313-329.