Sexual Violence Community Research

Understanding barriers to reporting sexual violence and accessing services in Coventry and Warwickshire

A Report by MBARC
for NHS Coventry, Warwickshire Police and NHS Warwickshire

Alasdair Stuart and Helen Davies
with Stephen John and Jennifer Reiter

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MBARC
94 White Lion Street
London N1 9PF
T: 020 7407 4010
www.mbarc.co.uk

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EXECUTIVE SUMMARY

1.1 INTRODUCTION

MBARC was commissioned in February 2012 by Coventry and Warwickshire Sexual Assault Strategic Board to undertake research to understand the barriers to reporting sexual violence or seeking services and support following assault, with a focus on diverse groups.

The objectives of the research were to:

- understand the barriers to reporting sexual violence to the police or accessing support services, with a focus on diverse groups including men, LGBT communities, sex workers, ethnic minority groups, and adults with learning disabilities or mental health issues.
- develop behaviour change recommendations to increase the reporting of sexual violence and to increase access to local services.

The research was commissioned with a view to seeking to reduce barriers and improve accessibility and responsiveness in the planning, promotion and delivery of local services, notably the new Sexual Assault Referral Centre (SARC).

1.2 METHODOLOGY, APPROACH AND RESEARCH PARTICIPANTS

Methodology

The methodology consisted of:

- Brief desk research stage
- Scoping and development of engagement tools
- Engagement and consultation with key stakeholders
- Analysis and reporting.

Approach

The engagement approach and research tools were designed to encourage anyone to respond to the consultation as we were keen not to exclude those with direct experience they chose not to disclose, or those with indirect experience of sexual violence. The research brief was to engage with adults and the approach and stakeholders contacted reflected this.

In order to introduce people to the topic more gently, the research tools first asked respondents to consider their experiences of local services (police, NHS and other support services) in general, before then asking them to consider these services in relation to sexual violence more specifically.

This was also considered relevant to the research because community or individual perceptions of statutory services as a whole may be an important barrier to accessing any assistance or support services, including those specifically provided in response to sexual violence.

Generally those organisations we were able to speak with directly were enthusiastic about the research, keen to participate as an organisation and willing to publicise the research through their networks and encourage or assist individuals that they worked with to respond to the consultation. A flexible approach was taken to how best organisations and individuals could be consulted, guided by the organisations that we spoke with, and what they felt would be most feasible.

Research Participants

The research engaged individual adults, and relevant groups and organisations through a variety of approaches and heard back from them in a range of ways.

In total 123 individuals responded through surveys or semi-structured discussions and groups, 15 organisations completed surveys, and meetings were held with an additional 10 organisations with 31 staff contributing to the consultation through these meetings, semi-structured interviews or group discussions with researchers.

Specific targeted communities included:

- Lesbian, Gay, Bisexual and Transgender (LGBT) communities
- Ethnic minority groups
- Men
- Sex Workers
- Adults with learning disabilities
- Adults with mental health issues.

1.3 FINDINGS AND RECOMMENDATIONS

The findings of the research have important implications for policy and practice from national through to local levels, and highlight the crucial importance of further work to improve the responsiveness of the Criminal Justice System and to raise awareness of victims' rights within it. Similarly they demonstrate the on-going need for concerted efforts to challenge the myths and misconceptions about rape and sexual assault and to raise public awareness of the services and support available to people who have been assaulted.

However, for the purpose of this report, the recommendations focus on actions that can and should be taken locally and those issues the Coventry and Warwickshire NHS, Police, and other Board members are best placed to influence.

The recommendations below are relevant to the SARC Board's commitment to improving both health and forensic outcomes for local people and have particular implications for partnership work to deliver the new Sexual Assault Referral Centre.

These recommendations for local consideration and action are in three main categories:

- Raising public awareness and providing tailored information to local communities
- Facilitating easier access to specialist advice and support
- Providing responsive and high quality services.

Each of these is likely to have relevance to the planning, promotion, and delivery of services at the Blue Sky Centre, and additional recommendations specific to this new SARC are also highlighted.

The recommendations in the four sections below are inter-related and action in one area is likely to be mutually reinforcing in other areas. For example, success in increasing the number of people reporting assaults to the Police and seeking health services will depend on coordinated action on relevant suggestions about raising awareness of these services, ensuring they are accessible, and delivering high quality, person-centred responses.

Raising public awareness and providing tailored information to local communities

The research identified that lack of awareness about and confidence in services is a significant barrier to seeking Police protection or NHS services. There are widely help misconceptions about how services operate and about the loss of choice and control that accessing them may generate for individuals.

We recommend the following areas are prioritised for local action and, in each case, suggest that the experience and expertise of local community organisations and trusted representatives is sought. Several of those engaged in this project expressed an interest in supporting future partnership work to tailor messages to be appropriate to diverse groups, and to promote effective dissemination of information making use of their reach into local communities.

Recommendation 1: Seek to raise awareness that rape and sexual assault can affect women, men, young people and children from every community and that victims are entitled to access Police protection and a range of services from the NHS and other local organisations.

Recommendation 2: Actively promote exiting and new services, dispelling myths about how they work and highlighting the benefits of reporting sexual assault and seeking specialist advice, support, and services to support recovery and promote criminal justice outcomes.

Recommendation 3: Develop and disseminate clear rights-based information about what to expect when reporting to the police or seeking help from health services, with emphasis on confidentiality and privacy, and on choices at every step of the pathway.

Recommendation 4: Recognise and harness the power of the local media in telling individual's stories about what happens when reporting assault or accessing services

with a view to having a more positive impact on willingness to report or disclose sexual assault and to seek help.

Facilitating easier access to specialist advice and support

On-going work is needed to clarify the respective roles of existing and planned services to ensure the best possible advice can be provided about local options for meeting diverse needs including those related to culture, ethnicity, mental illness, learning disabilities, or substance misuse. The recommendations below relate to facilitating access to current and planned services, and are not based on analysis of the coverage these are likely to provide. For example, the research did not include detailed consideration of sexual violence prevalence estimates applied to local population and demographic data, and further work on this may be required in future.

As well as issues related to limited awareness of or confidence in statutory services, respondents raised a number of important points about attitudinal and practical barriers to accessing help following rape or sexual assault. Based on the responses of individuals and organisations, the following emerge as priorities for local action to make services more accessible to diverse local communities:

Recommendation 5: Provide safe options for reporting to the Police or seeking help from the NHS, recognising that the need to disclose personal information in reception areas with limited privacy is a significant deterrent for many.

Recommendation 6: Establish a single point of telephone advice and access to sexual assault services, staffed by experts from the outset i.e. not requiring clients to go through hospital or police switchboards.

Recommendation 7: Facilitate access to a range of safe places for Police interviews so individuals do not have to attend a police station to report an assault, make a statement, or engage in other steps in the criminal justice process.

Recommendation 8: Promote positive, well-informed, and supportive attitudes within generic public services, particularly frontline reception staff, raising their knowledge of sexual violence and their awareness of the importance of the recognising the needs of victims and not making assumptions based on how they present or who they are.

Recommendation 9: Offer the option of speaking to a woman or man to report an assault or to discuss needs for support, advice or services.

Recommendation 10: Facilitate access to interpreting and language support which must be provided by carefully selected and trained individuals and recognise the critical importance of confidentiality and of impartiality.

Recommendation 11: Clearly define and share information about pathways into local services and links between Police, NHS, and third sector providers of sexual violence services of provision.

Providing responsive and high quality services

Individuals and organisations emphasised the importance of seeking to ensure local people have access to specialist Police and NHS staff with expert knowledge both related to sexual violence and good awareness of the complex needs of victims with specific needs related to mental health, learning disabilities. In addition, they stressed the importance of responsive services planned around the individual and their needs, not on assumptions related to culture, lifestyle, or identity. Priority areas relating to the quality of services are summarised below:

Recommendation 12: Seek to ensure the Police and NHS response is appropriate and sensitive to individuals' needs, right from the very first point of contact with the service, and is based on clearly defined and publicised quality standards.

Recommendation 13: Protect the privacy and dignity of victims or service users, and ensure there is an explicit focus on offering clear choices and securing informed consent at every stage of contact with services.

Recommendation 14: Improve the communication with victims or service users about progress in cases reported to the police and provide better explanations and support when cases are not taken to court or when there is no conviction.

Recommendation 15: Invest in training sexual violence staff in the diverse needs of victims and in raising other organisations' awareness of sexual violence and how to support people to safely disclose experience and access appropriate support and service.

Recommendation 16: Seek to improve access to longer-term counselling, support and help for people with historic abuse and on-going problems (such as lack of confidence or self-esteem) or concerns (such as a need for help with anger management, or worries about their own behaviour towards partner/s).

Additional recommendations for the new SARC services

The researchers welcome the commissioners' commitment to using the findings of this research to influence planning, publicising, and providing services at the new Blue Sky Centre. The above recommendations all have relevance to this commitment, and in addition the research identified specific suggestions for the SARC, as summarised below.

Recommendation 17: In raising public awareness of the Blue Sky Centre, we recommend the following suggestions are considered:

- seek to counter negative media coverage and challenge myths and fears about services
- make concerted efforts to convey that the SARC is a welcoming service for EMG, LGBT, disabled, learning disabilities, mental health, men, people who sell sex

- provide information in different languages and formats, recognising some people may need to access information online, others in written form, others by word of mouth
- invest in outreach through established community groups and trusted representatives
- provide clear information about entitlement to accessing help from the Police and/or NHS without disclosing personal details
- promote positive messages about the services, choices available, and benefits of getting help following rape or sexual assault.

Recommendation 18: In promoting access to the Blue Sky Centre, the following practical considerations should be addressed:

- the need to be very clear on the remit of the SARC, what services are available and who it is for
- the choices and process for people accessing the services, and what happens afterwards
- develop and maintain good links to referral agencies including both specialist organisations and generic services to which people may initially present
- clear statements in all publicity regarding confidentiality and privacy
- minimal waiting times, efficient appointments systems, and opening hours to suit clients
- accessible transport links
- safe discreet access to the SARC without it being obvious to onlookers who is attending
- a safe, supportive environment within the SARC and pleasant surroundings.

Recommendation 19: In ensuring services at the Blue Sky Centre are responsive to diverse needs and consistently high quality, priorities should include:

- ensuring all staff are suitably trained and supervised to deal with the range of clients who may need to access SARC including people with mental health issues or learning disabilities
- making good use of local experience and expertise in training staff, both in sexual violence issues and diversity considerations, and emphasising the expectation that staff are sensitive, empathetic, and able to provide tailored responses to individual needs
- protecting the safety of service users and ensuring they are seen by SARC staff in private, without family members or 'escorts' in the room
- offering a choice of gender of staff to talk to about the rape or assault and to provide advice and psychosocial support
- providing access to staff with variety of language skills, or translators who have been very carefully selected and trained, recognising the perceived risk of translators from EMG communities disclosing information about clients, or not translating appropriately
- minimising the number of times an account of the rape or sexual assault has to be given by the victim to different staff

- protecting the dignity of clients throughout the examination process and afterwards, including provision of clothes for those who are not able to have their own brought in
- considering and making arrangements for leaving the SARC following initial appointments, particularly at night, ensuring people have someone trusted and/or somewhere safe to go to
- establishing and promoting good links between the SARC and services that may refer to or take referrals from the centre and a wider network of local organisations working with diverse communities and vulnerable groups.

2 INTRODUCTION

2.1 INTRODUCTION

MBARC was commissioned in February 2012 by Coventry and Warwickshire Sexual Assault Strategic Board to undertake research to understand the barriers to reporting sexual violence or seeking services and support following assault, with a focus on diverse groups.

The objectives of the research were to:

- understand the barriers to reporting sexual violence to the police or accessing support services, with a focus on diverse groups including men, LGBT communities, sex workers, ethnic minority groups, and adults with learning disabilities or mental health issues.
- develop behaviour change recommendations to increase the reporting of sexual violence and to increase access to local services.

The research was commissioned with a view to seeking to reduce barriers and improve accessibility and responsiveness in the planning, promotion and delivery of local services, notably the new Sexual Assault Referral Centre.

MBARC is a specialist research consultancy with extensive expertise in using a range of research and engagement mechanisms with the target communities the commissioners wanted to hear from in the course of the research. The consultancy also has a track record of applying research and community intelligence to influence the development of policies and delivery of services. Brief information on the MBARC team is provided in Appendix 2.

MBARC gratefully acknowledges the contributions of a range of local organisations and individuals to the research, and the openness of the NHS and Police commissioners to hearing communities' perceptions or experience of local services and their suggestions about how to make them more accessible.

2.2 CONTEXT

The impact of sexual violence can be profound and far reaching for individuals, their families and friends. For individuals there are immediate risks to both physical and sexual health and medium to long term risks to mental health and wellbeing, with many victims experiencing depression, substance misuse, anxiety and even suicide.

There have been a series of reports and policy developments giving a greater emphasis on the impact of sexual violence both to the victim and wider society and the roles of the statutory agencies - notably the NHS, Police, Local Authorities and third sector agencies - to work together to provide safe and effective services that meet the full range of a victim's needs. One of the main innovations is the development of local Sexual Assault Referral Centres (SARCs). A SARC is a one-stop-

shop centre where victims of rape or sexual assault (men, women, young people, and children) can access specialist forensic medical examination and treatment, and benefit from a holistic range of services to support their recovery. Individuals can access services whether or not they are willing and able to report the assault to the Police, and where individuals have reported, SARCs can play an important part in supporting wider forensic / criminal justice outcomes as well as supporting the individual client.

A Coventry and Warwickshire Sexual Assault Strategic Board has been formed comprising representatives from Warwickshire Police, NHS Coventry and NHS Warwickshire, Crown Prosecution Service, Warwickshire County Council and Coventry City Council and representatives from the third sector rape support agencies in Coventry and Warwickshire. The aim of the board is both to increase prosecutions and support victims.

The Coventry and Warwickshire Sexual Assault Strategic Board is currently in the process of designing and building a new purpose built SARC, to be called 'The Blue Sky Centre'. The SARC will be located at the George Eliot Hospital and will take referrals from acute and historical victims (children, young people and adults – male and female) of rape, sexual assault and abuse. It is anticipated that the SARC will be open to police referral in October or November 2012 and to self-referrals in early 2013.

This research will contribute to the development of the SARC service by both identifying the barriers and recommending solutions to increase reporting. Communities' views, experience and suggestions are relevant to various aspects of delivering the new service and have particular relevance for staff training, access arrangements, and publicity plans.

2.3 METHODOLOGY

The methodology consisted of:

- Desk research
- Scoping and development of engagement tools
- Engagement and consultation with key stakeholders
- Analysis and reporting
- Presentation of final report to SARC board

Desk research

A brief desk research phase involved examining directly relevant academic research[1], local population and demographics information, community consultations and

1 Including the following:

- "Forging the links: Rape investigation and prosecution - A joint review by HMIC and HMCPSI", Criminal Justice Joint Inspection (2012), http://www.hmic.gov.uk/publication/forging-the-links-rape-investigation-and-prosecution/

Equality Impact Assessments for relevant national strategies and local experience to date including the 2011 consultation on sexual violence led by Warwickshire County Council and Police, and other relevant consultation by local services.

Scoping and development of engagement tools

The scoping stage of the research involved identifying relevant local community groups, networks and organisations working with the various community groups identified in the brief, as well as specialist services working with adult victims of sexual violence.

An 'Invitation to Engage' leaflet was designed giving information about the research, detailing how organisations and individuals could participate in the research and what they could expect from the process. A 'Did You Know?' section was also included, as a way to raise awareness of issues around sexual violence and challenge certain stereotypes about rape and sexual assault. The research brief was to engage with invitation to engage reflected this.

The research was designed so that people could participate either face-to-face, by telephone or online. An online survey was developed with sections for either individuals or organisations to complete, and interview guides for interviews/group discussions with professionals from relevant organisations and individual service users were also developed (which included guidelines for action in the event of disclosure).

The 'Invitation to Engage' and research tools were designed to encourage anyone to respond to the consultation as we were keen not to exclude those with direct experience they chose not to disclose, or those with indirect experience of sexual violence. In order to introduce people to the topic more gently, the survey and interview guides first asked respondents to consider their experiences of local services (police, NHS and other support services) in general, before then asking them to consider these services in relation to sexual violence more specifically. This was also considered relevant to the research because community or individual perceptions of statutory services as a whole may be an important barrier to accessing any assistance or support services, including those specifically provided in response to sexual violence.

- "Revised National Service Guide - A Resource for Developing Sexual Assault Referral Centres", Home Office, Association of Chief Police Officers, NHS (2009), http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_107570
- The Stern Review: A Report by Baroness Vivien Stern CBE of an Independent Review into how Rape Complaints are Handled by Public Authorities in England and Wales, Government Equalities Office (2010), http://www.wrc.org.uk/includes/documents/cm_docs/2011/1/100315_stern_review_of_rape_reporting_1final.pdf
- "Rape: The Victim Experience Review", Sara Payne MBE, Victims' Champion, on behalf of the Home Office (2009), http://wnc.equalities.gov.uk/publications/doc_download/421-rape-the-victim-experience-review.html

The ‘Invitation to Engage’, online survey and interview guides can be found in Appendix 1.

Engagement and consultation with key stakeholders

Relevant organisations, community groups and networks identified in the scoping stage were initially contacted by email to inform them about the research and to ask for their assistance by participating in the research themselves, and encouraging service users/individuals that they worked with to participate as well.

This email contained a link to the online survey (with the offer of supplying paper copies if required), as well as the ‘Invitation to Engage’ leaflet, which we suggested could be used to promote the research electronically and by displaying it in relevant places. The research team also contacted members of the Sexual Assault Strategic Board (via Warwickshire Police), and the community liaison or consultation leads in Coventry NHS, Police (via West Midlands Police) and City Council, and Warwickshire NHS, Police, and County Council. The purpose of this contact was to inform local organisations about the research, encourage them to raise awareness through their contact with local communities, and invite them to alert the researchers to existing reports of particular relevance.

Initial ‘Invitation to Engage’ emails were followed up by telephone calls to speak to relevant staff within organisations and networks, to talk to them about the research in more detail and respond to any queries or suggestions, encourage them to participate and ask for their help in publicising the research and helping us to identify individuals who would be willing to participate in the research.

Generally those organisations we were able to speak with directly were enthusiastic about the research, keen to participate as an organisation and willing to publicise the research through their networks and encourage or assist individuals that they worked with to respond to the consultation. Several specifically commented on how pleased they were that community views were being sought before new services were up and running, rather than waiting until they were well established, and were motivated to continue to be engaged as the SARC service opens and develops over time.

A flexible approach was taken to how best organisations and individuals could be consulted, guided by the organisations that we spoke with, and what they felt would be most feasible. Travel expenses for individuals were covered and a small incentive offered for interviewees, but in practice the majority of individuals chose to respond through the survey rather than in person, and many used this process to share detailed experience and views. The direct additional costs to organisations of hosting focus groups or consultation events were also covered.

In total, 108 individuals took part in the surveys and 15 individual service users shared their experience and suggestions through semi-structured interviews and discussions. In addition, 15 organisations completed surveys, and meetings were held with an additional 10 organisations with 31 staff contributing to the consultation

through these meetings, semi-structured interviews or group discussions with researchers. Information about the individuals and organisations we heard from in the course of the research is provided in section 1.4 below.

Analysis and reporting

Information gathered from the different elements of the consultation was collated and systematically analysed to identify emerging and recurring themes, examine differences in opinions, identify illustrative examples and develop recommendations.

The research team had regular contact with NHS Coventry and Warwickshire Police as the lead contacts for the project, and provided them with information updates as the research progressed. A comprehensive draft report presenting our findings and recommendations was then submitted to the research commissioners, with feedback and comments incorporated into a final draft report for members of the Board.

The findings of the research and our conclusions and recommendations were presented to the Coventry and Warwickshire Sexual Assault Strategic Board on 3rd of August 2012 for information and consideration in relation to their continued work to improve local responses to sexual assault. The final report will be circulated to all who contributed to the research and made widely available by the commissioners and Board members.

2.4 RESEARCH PARTICIPANTS / RESPONDEES

Survey respondents/participants

The majority of respondents to the consultation chose to use the online survey, with 125 people starting the survey, and 70 fully completing it (a completion rate of 56.0%). Of the survey respondents 87.8% were responses from individuals, with 12.2% from people responding on behalf of an organisation. The survey responses were anonymous but individuals were encouraged to complete demographic information and most did, and organisations were invited to identify themselves. Of the 15 organisations completing the survey, three identified themselves - Valley House (domestic abuse service), Barnado's (Defuze project), and THT SWISH (working with sex workers and the LGBT community).

Of those responding to the survey 73.0% (54 respondents) said that they knew someone who had been raped or sexually assaulted, and 65.8% (48 respondents) said they had heard about local services for people who have been raped or sexually assaulted[2].

Of those that who supplied demographics information (68 survey respondents):

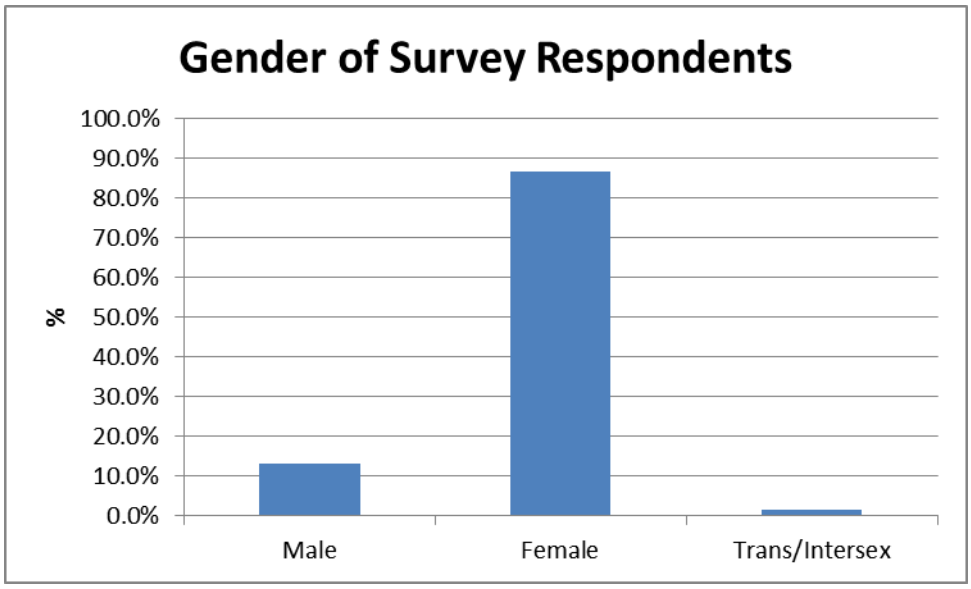
- 86.8% were female, 13.2% male and 1.5% Trans or Intersex

2 Figures given are the percentage of respondents who answered each question, rather than the total who completed the survey (as not all respondents answered each question).

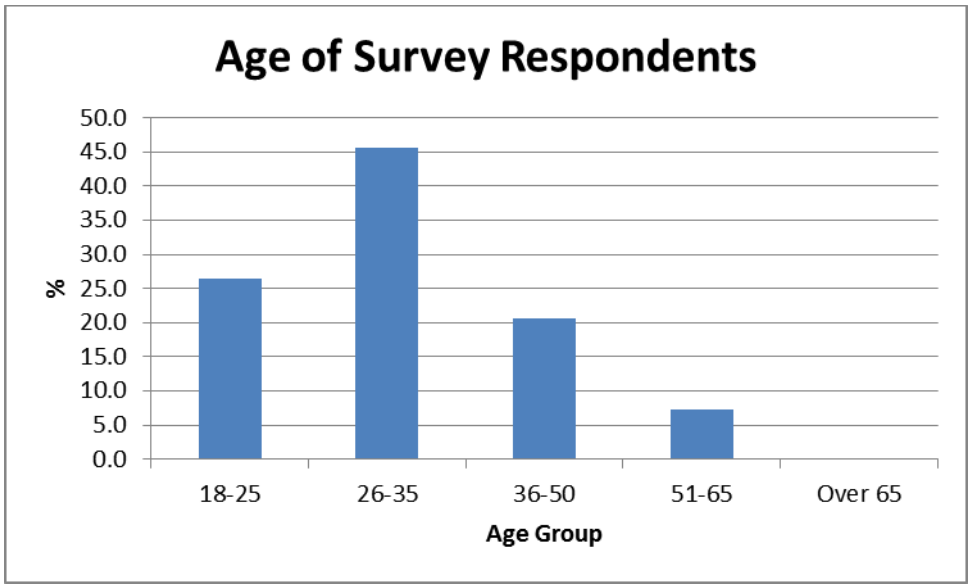
- The majority were aged between 26-35, with a significant number aged 18-25 and 36-50, and a relatively small number aged 51-65.
- 61.2% were White, with 38.8% coming from Ethnic Minority Groups
- 31.3% were from the LGBT community
- 10.9% were people who sell sex
- 23.4% were adults with mental health issues
- 9.4% were adults with learning disabilities.

Graphs 1 to 5 give more details on the demographics of the survey respondents.

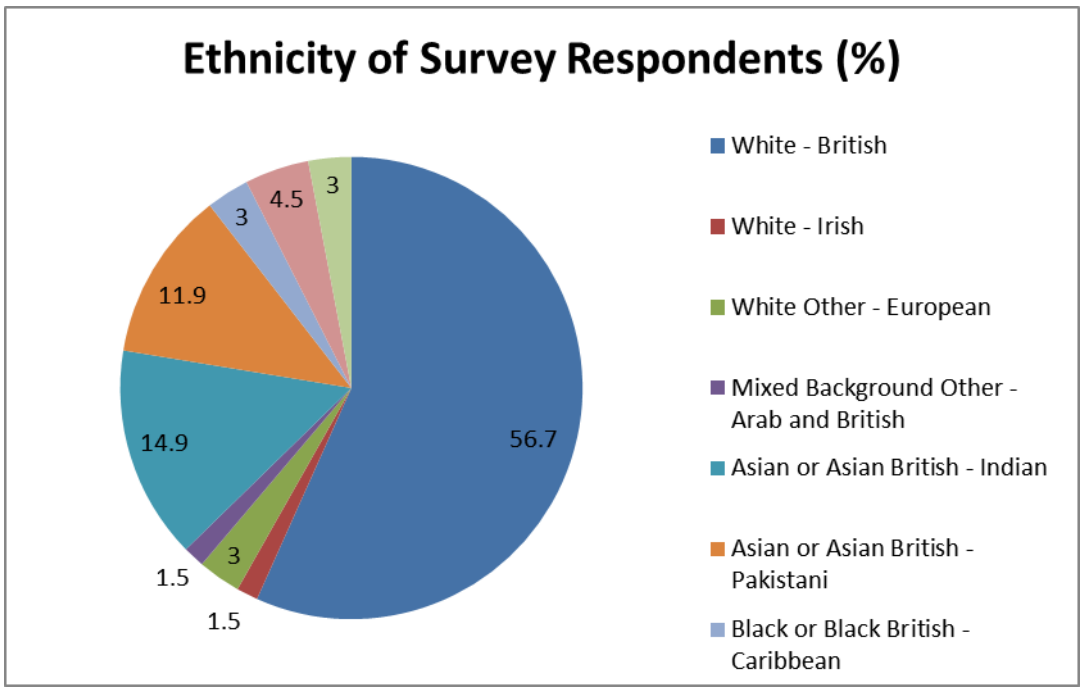
Graph 1: Gender of Survey Respondents



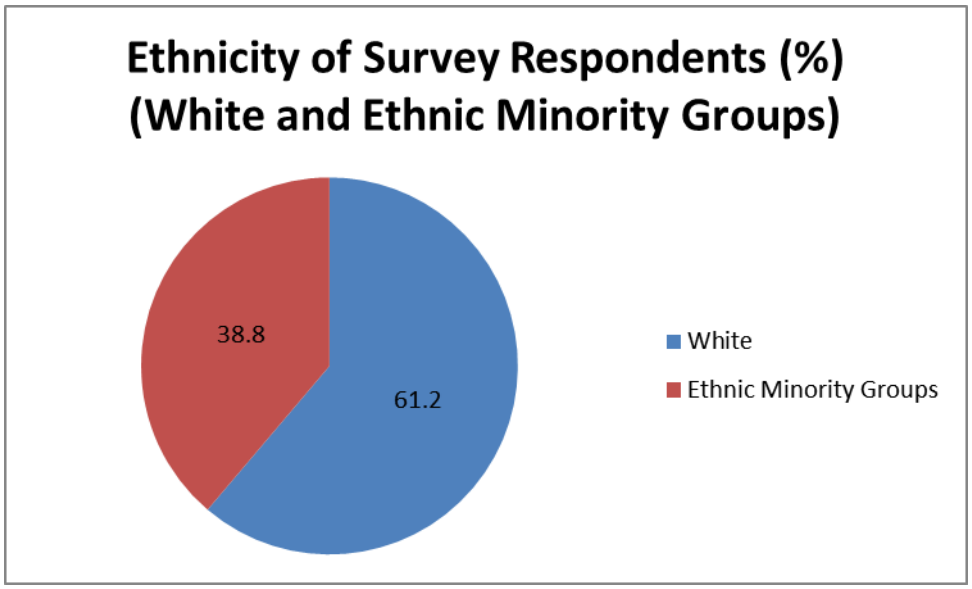
Graph 2: Age of Survey Respondents



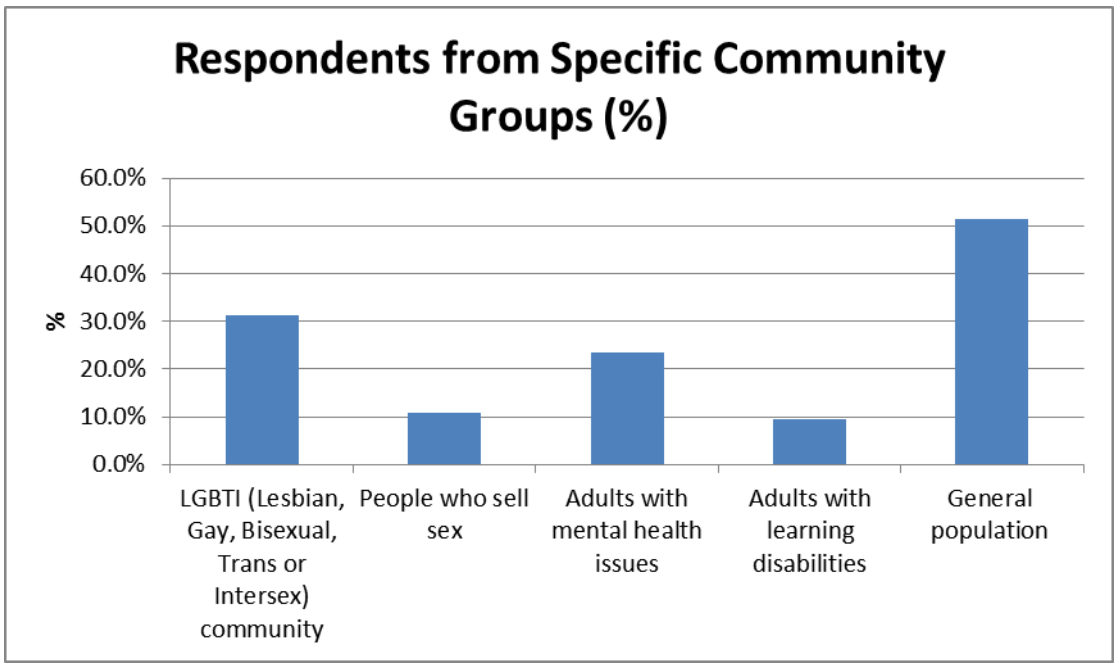
Graph 3: Ethnicity of Survey Respondents



Graph 4: Ethnicity of Survey Respondents Grouped



Graph 5: Survey Respondents from Specific Community Groups



Other respondents/participants

In addition to the survey, a number of visits were conducted to interview staff and in some cases service users from a range of other relevant organisations, namely:

- Coventry Actively Influencing Mental Health Services (AIMHS) (working with adults with experience of mental health services)
- Coventry and Warwickshire Mind (working with adults with mental health issues)
- Coventry Rape and Sexual Abuse Centre (CRASAC)
- Coventry University Student Support and Health Services
- Grapevine (working with adults with Learning Disabilities)
- Life Path Trust (working with adults with Learning Disabilities)
- Panagher (working with Asian people experiencing domestic violence)
- Push Projects (working with LGBT community)
- Rugby Rape or Sexual Assault Support Services (ROSA)
- Whitefriars Housing Group, Chace Centre (centre for homeless men)

Across these organisations staff directly engaged with MBARC researchers to share their experience and views, mainly based on working with people who have been raped or sexually assaulted. Throughout this process, researchers were aware that

some staff may also have undisclosed direct experience but no assumptions about this have been made in discussions with them or this report.

In addition, several organisations made specific arrangements to enable or encourage their service users to participate in the research, as follows:

- Coventry AIMHS hosted a service user forum attended by twelve people with lived experience of mental illness and mental health services and three staff. Two MBARC researchers explained the purpose of the research and facilitated a group discussion based on the questions in the interview guide.
- Following a planning meeting between the researcher and staff, Panagher hosted two consultation groups for Asian women at which they explained the research in appropriate community languages and were on hand to translate specific questions as individual women completed hard copies of the survey. 13 individual responses were submitted following this process.
- The Push Project invited a researcher to attend one of their user groups for young LGBT people and encourage members of their group to respond. Unfortunately attendance was unusually low that evening, but the group's facilitators subsequently encouraged forum members to respond to the online survey.
- Whitefriars Housing Chace Centre invited the researcher to attend a drop in session for homeless men and to be on hand to interview individuals or encourage them to complete hard copies of the survey and five individual responses were submitted and two interviews conducted on the day.

Reporting our findings

As detailed above, the research engaged individuals, groups and organisations through a variety of approaches and heard back from them in a range of ways. In total 123 individuals responded through surveys or semi-structured discussions and groups, 15 organisations completed surveys, and meetings were held with an additional 10 organisations with 31 staff contributing to the consultation through these meetings, semi-structured interviews or group discussions with researchers.

The remainder of this report summarises findings from all the responses gathered during the research period, and makes recommendations for local consideration, as well as providing additional background information. It is set out as follows:

- Chapter 2: Experiences of generic local services
- Chapter 3: Barriers to reporting rape and sexual violence to the police, NHS and other support services and suggestions to encourage reporting
- Chapter 4: Issues for particular groups
- Chapter 5: Recommendations
- Appendix 1:
  - Invitation to contribute
  - Survey
  - Interview Guides
- Appendix 2: Information about the research team.

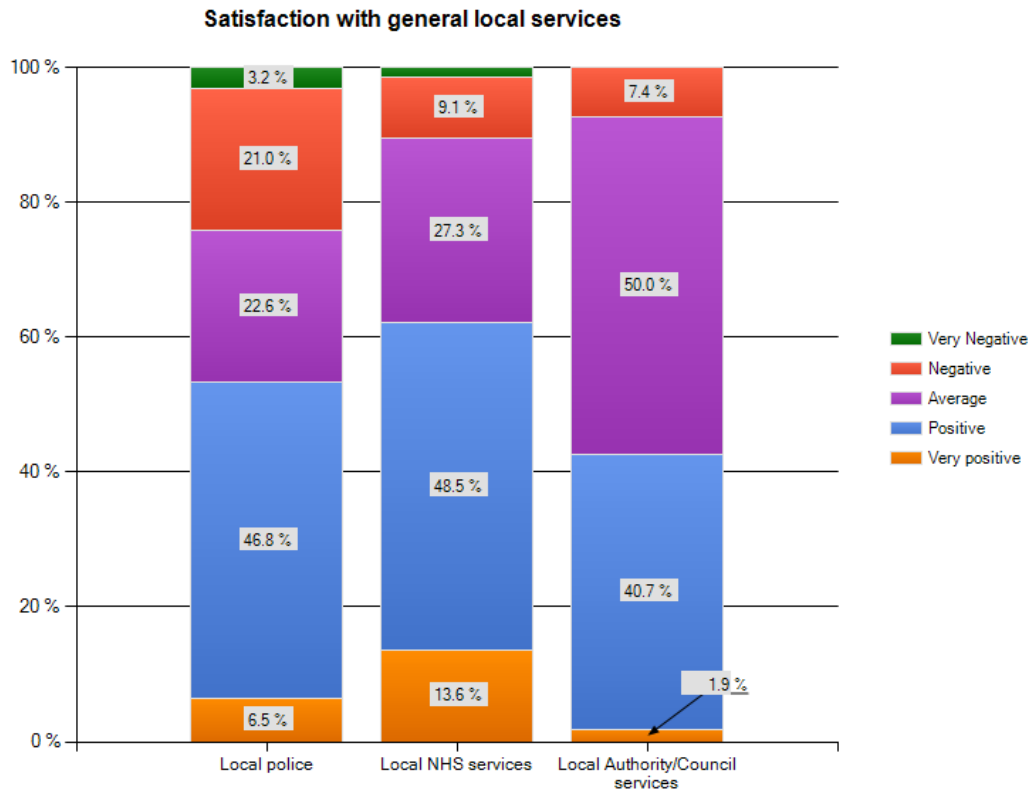
3 EXPERIENCES OF GENERIC LOCAL SERVICES

3.1 EXPERIENCES OF LOCAL SERVICES

Survey respondents were asked to rate their experiences of using generic local services, including the police, NHS and local authority/council services. They were not asked to specify which services they had experience of, so the results below reflect reported experience of a range of Coventry and/or Warwickshire services.

As Graph 1 shows, local NHS services were rated most positively, with 62.1% of respondents rating these as 'positive' or 'very positive'. The local police had the most negative rating, with 21.0% of respondents saying they had had a 'negative' experience, and 3.2% saying they had had a 'very negative' experience.

Graph 1: Satisfaction with generic local public services



3.2 BARRIERS TO ACCESSING LOCAL SERVICES

Those that we consulted with were asked whether they felt there were any barriers to accessing local services, including the police, NHS and local authority/council services. Respondents reported experience and/or perceptions of a number of barriers to accessing these services, as summarised below.

Experience of discrimination

For a number of respondents a barrier to using general local services was a perception that certain people may face discrimination or insensitivity from frontline staff in statutory agencies.

> "You're always going to get some staff in these places who are not friendly, who look down on you, who discriminate for some reason."

Respondents suggested this could take the form of ignorance or insensitivity to cultural issues, to discrimination against EMG communities, disabled people and the LGBT community.

> "Frontline staff in the respective public services do not always come across as being very nice towards to LGBT community."

> "Black people and people from ethnic minority backgrounds are openly discriminated against."

Confidentiality and privacy issues

Those that we consulted with mentioned that confidentiality and privacy concerns were a barrier to using general local services, with concerns that their information may not remain confidential, or that people will be able to identify them accessing particular services in person. The lack of confidentiality at public/reception areas in public service buildings was a particular issue that was mentioned.

Cuts in services

A number of respondents suggested that cuts to local public services have/would become a barrier to accessing general services. Some mentioned this impacting on the availability of longer-term psychosocial support or advice and help to prevent anxieties becoming more serious problems. As one respondent said:

> "If there are fewer services available, it's going to be harder to access them."

Opening hours, waiting times and location of service

There were a number of practical issues which respondents suggested could act as barriers to accessing general local services, including opening times, the convenience of their location, costs involved in parking and transport links, and waiting times to be seen.

Lack of awareness and information on services

A further barrier to accessing general public health services which respondents mentioned was a lack of information on and awareness of what services are available. Typical comments included:

"I'm not really sure where to go for some services."

"There's a lack of clear information available."

"It can be difficult to find telephone numbers on the internet for the specific services that you want."

3.3 SUGGESTIONS TO IMPROVE LOCAL SERVICES TO MAKE THEM MORE APPROACHABLE AND RESPONSIVE TO YOU OR YOUR COMMUNITY

Respondents were asked for suggestions for improvements that could be made to make general local services (including the police, NHS and local authority/council services) more approachable and responsive to them and/or their community. Suggestions included the following:

Clear information and promotion of services

Those we consulted suggested provision of clear information on what services are available, how they can be accessed, what patients or service users can expect in terms of confidentiality and privacy, and what choices they are likely to have when visiting these services. As one respondent said:

"You need clear information about the range of services out there, how you can access them, what your options are when you go there, and to be reassured that it will be confidential."

Respondents also suggested that services should be promoted more effectively in a variety of places and in a variety of different ways.

"There needs to be better advertisement of the services available in relevant Places."

"There should be more advertisement of the services available and how to contact
Them."

Positive messages and staff

One of the key suggestions that those that we consulted with had for improving local services in general was for frontline staff to have very positive and welcoming attitudes, with a focus on empathy for service users.

"Staff at local services need to have a change in attitude, to be more positive, have more empathy for service users, and listen more carefully to their needs."

> "There should be a shift in attitude towards treating people with a basic dignity and respect, with service users as 'customers'. That would go a long way towards ensuring that people have a positive perception of the service."

Staff with specialist skills and expertise

Respondents suggested that local services need staff with specialist skills and expertise in dealing with a wide range of people, from EMG communities, to people with learning disabilities and mental health issues.

Translated information and staff with language skills

A number of respondents suggested that local services should be promoted in a range of different languages, and that staff should have a range of language skills to be able to communicate with people from communities whose first language is not English. As one respondent put it:

> "There should be translated information available in various languages, with staff from different community groups so that they have language skills to communicate to them in their own language."

Opening hours, waiting times and location of service

Another improvement to local services suggested by respondents was to reduce the time spent waiting to be seen by local services, ensure that they have convenient opening times and that services are easily accessible by public transport.

Partnership working and referrals

The final suggestion that those that we consulted with had to improve local services in general was better communication and partnership working between different agencies, and more involvement for and onward referral to third sector voluntary organisations.

> "There should be more involvement with independent organisations, better referral on to these organisations if they are able to help."

> "Local public services to work more closely together, so you don't have to go to lots of different places about the same problem. They should be able to share information more easily."

4 BARRIERS TO REPORTING RAPE AND SEXUAL VIOLENCE TO THE POLICE, NHS AND OTHER SUPPORT SERVICES AND SUGGESTIONS TO ENCOURAGE REPORTING

4.1 BARRIERS TO REPORTING RAPE OR SEXUAL VIOLENCE TO THE POLICE

Those that we consulted with were asked whether they felt there are any barriers to reporting rape or sexual assault to the police. The vast majority of respondents said that there were (including 56 individuals and 17 organisations from those responding to the survey). The barriers mentioned included the following:

Myths and stereotypes around rape and sexual violence

Another common barrier reported by respondents was concern about the various myths and stereotypes which exist around sexual violence, which are reinforced daily in society and through the media. Respondents felt that general social attitudes to rape almost seem biased towards the alleged perpetrator, with the victim being guilty of allowing the rape or sexual assault to have happened, of somehow being to blame, or having to prove their not lying.

> "There seems to be an attitude of victim blame both in the media and in society as a whole."

For some respondents this extended to being unsure about whether sexual assault or rape could take place if you were in a relationship with someone.

> "Some people don't know that non-consensual sex within a relationship is still Rape."

Lack of faith in the justice system

Another barrier mentioned frequently was a lack of faith in the justice system to Convict someone that a victim has reported as having carried out a rape or sexual assault. Respondents identified a number of factors contributing to this lack of faith, including an awareness of the low conviction rates for rape and sexual assault, a perception that the police require significant evidence before they will consider investigating a reported rape or sexual assault, and a feeling that often the victim is unlikely to be believed, and that the perpetrator has 'more rights' than the victim.

> "My perception is that the reporting to conviction rates are appalling."

> "Even if you are believed in the first place, the conviction rates are so low, you wonder what the point is."

> "My own experience was that after three people reporting the same perpetrator, it was still found in the public interest not to pursue a

conviction. Was it worth reporting it? No! Did he go on to abuse other children? Yes! Did he ever see court? No!"

"Police don't investigate unless there is loads of evidence which often there isn't."

"It feels as though the alleged perpetrator has more "rights" than the victim."

A number of respondents also felt that the way a victim is treated in court would put them off reporting to the police.

Trust issues, being exposed and reaction of family and friends

For a large number of respondents one of the main barriers to reporting to the police was an issue of trust, with many concerned that doing so was likely to lead to other people finding out that they have been the victim of sexual violence, and concern about how family, friends, colleagues and employers would react to finding out.

For many people the risk of people finding out that they had been a victim of rape or sexual assault was seen as simply too great to report to the police. As one respondent put it:

"The risk of people finding out, such as family, is just too great."

"Many women are scared of the reaction of their husbands, family and society. For some it's easier just not to say anything."

"You're scared that your sexual history will be exposed, will be brought up, that previous sexual partners may become involved."

For others the main fear was of the repercussions if the offender found out that they had reported to the police.

"I'd be really scared about what might happen if he [perpetrator] found out I'd gone to the police. It's not just you that you have to worry about, it's your family, your children as well."

"Many of these assaults are by people you know, so if your family find out, often the perpetrator will find out that you're gone to the police."

Shame, stigma and concern about not being believed

By far the most common barrier mentioned by respondents was around the issue of the negative emotions they would feel when reporting a rape or sexual assault to the police, and a real fear that they may not be believed when doing so.

These feelings included deep shame, guilt and disbelief at being the victim of sexual violence, having very low confidence and being afraid of telling others, and being worried about the stigma attached to being a victim of rape or sexual assault. Many people were seriously concerned that they simply would not be believed if they reported.

> "You feel bad, really low in confidence, really uncomfortable talking about it."

> "There would be real shame, and blame and stigma about putting yourself in that position."

> "I'd be worried that I'd be blamed for the attack."

> "There's definitely a perception you won't be believed, like you have to go out of your way to prove you're not lying."

Peer pressure for young women/girls

One respondent suggested that for young girls/women a potential barrier to reporting to the police could be that they would be bullied or ridiculed for involving the authorities, potentially by their peer group, who may see having sex (whether consensual or not) as part of growing up.

> "For some girls, having sex with older guys is what you do, and girls who don't want to could be bullied if they're not willing to do the same, or bullied if they went to the police about something like that."

Removal of control over process

Another common barrier mentioned by a large number of respondents was concern that once you report to the police you lose the power to control the process, and you will no longer have fundamental decision making over issues that relate to yourself, such as whether to prosecute and go to court or to withdraw a complaint.

> "There's a fear that you're starting a process where you will be removed from the decision making process."

> "I'd be concerned there would be a loss of control about what happens next."

For other respondents the issue was not knowing what the process would involve, what control they would have over it, and what their options would be. For some this included a fear that they would get in trouble if they decided to withdraw charges at some point.

> "I just don't know what happens if you go to the police. Whether it's out of your hands, or you have the right to decide to withdraw if you want. That would put me off."

> "I'd be worried that I'd be penalised if I decided to withdraw charges at a later date."

Some Coventry respondents were concerned that if they reported to local Police they would not have the option of going to the new SARC.

Attitude of staff, discrimination in statutory agencies

A further barrier to reporting to the police that was identified by a number of respondents was concern that the attitude of frontline staff would be insensitive, or in some cases discriminatory, to victims of sexual violence, particularly those from certain groups including sex workers, men, EMG communities or people whose first language is not English, LGBT people, those misusing alcohol or drugs, the homeless, those with mental health issues or learning disabilities and those already known to the police.

> "There are certain prejudices you face when you go to the police."

> "I've overheard derogatory comments from police officers when dealing with complaint about a sexual assault."

> "The attitude you might encounter from frontline officers would put me off."

> "It usually feels as if the victim is the one on trial, there is almost presumptive implication that the victim is somehow responsible or guilty."

> "People are aware that the police can be openly racist and homophobic."

Fear of discrimination or police action for illegal activity

For a number of respondents from particular groups, especially sex workers and those misusing alcohol and/or drugs, another barrier was a fear that reporting a sexual assault or rape could result in them themselves getting into trouble with the police (e.g. for prostitution or drug use).

> "If you are a prostitute, or you are using drugs, you'd be concerned about getting in trouble from the police, so you'd be less likely to report something to them."

> "There's a fear of not being believed, or not been taken seriously if you're a sex worker or you're gay."

A number of those from the LGBT community felt that the police may be less likely to take action to investigate an allegation of sexual violence because various activities in the LGBT community may be viewed as 'risky behaviour', and that a claim of sexual assault may be seen in the context of a 'gay lifestyle'.

> "I'd be concerned they wouldn't take it seriously, as a gay man, they might think your sexual activity is promiscuous anyway, and it's just part of your lifestyle choice."

Gender of staff

Another issue raised by respondents as a barrier to reporting rape or sexual assault to the police was the gender of officers involved in the process of reporting a sexual assault or rape, in particular the involvement of male staff in the process. This extended from contact with frontline officers during the initial report to those transporting victims and those involved in taking the victim statement.

> "Having to report a sexual assault to a male officer would be distressing and would discourage people from doing so."

> "It would be embarrassing and shameful having to explain what happened to a male officer."

> "In a women's case men being involved in the reporting process is very upsetting."

Trauma of reliving experience repeatedly and time involved

A further barrier suggested by those that we consulted with was that reporting to the police would mean having to relive the traumatic experience, with a victim often having to retell what happened to them several times to different people/agencies.

For many respondents the prospect of having to relive the experience in this way, combined with the low rate of convictions, meant that reporting to the police seemed a very unappealing prospect.

> "Knowing that you are going to have to relive the experience, to relive those memories, that's really hard, and having to tell people several times what happened to you."

> "You face going through the trauma of repeating what has happened, only for no or little action to be taken in the end."

> "Knowing you will have to relive the incident again by telling the police what happened, and then telling them again while they write a witness statement, that would put me off doing it."

> "You might have to tell the police, then also explain to various other agencies what's happened to you, it gets too much."

In addition to this a number of respondents suggested that the time it takes to report, give a statement, and the possibility of having to take part in a lengthy court case would make them reluctant to report to the police.

> "The time it takes, how involved you have to be, telling people what happened over and over, and maybe nothing is done about it...you just think whether it's worth it."

> "The length of time it takes to report, and then the long wait to see if it actually gets to court, it takes too long."

> "Having to take time off work, some people just can't do that."

Having to have a physical examination

For some respondents, particularly women from EMG communities, another barrier mentioned that would prevent them from reporting a sexual assault or rape to the police is the fear that doing so will immediately lead to them having to get an intrusive forensic/medical examination.

> "I really wouldn't be comfortable with an intrusive examination."

One respondent mentioned having to wear paper clothing after a forensic examination (as their clothes had been kept as evidence), suggesting that they had found this 'de-humanising', and that this would put them off going through the process again.

Several respondents – individuals and organisational – thought there would be no point in someone going through a physical examination if they had showered or changed their clothes, or if more than a day or two had passed since the assault.

Poor relationships with the police

Some of those we consulted with said they would not be likely to report sexual violence to the police because they or their community had a poor opinion of the police in general, or had had bad experiences with them in the past. Comments included:

> "For some people they just don't trust the police, they may have had bad experiences with them in the past. They're not going to report to the police, no matter what it's about."

> "There is still a mental barrier to reporting to the police for many people, because of experiences they or people in their community have had of the police in the past."

4.2 BARRIERS TO ACCESSING HEALTH SERVICES AND OTHER SUPPORT IF YOU HAVE EXPERIENCED RAPE OR SEXUAL ASSAULT

Those that we consulted with were asked whether they felt there are any barriers to accessing health services and other support if you have experienced rape or sexual assault. The majority of respondents said that there were (including 38 individuals and 12 organisations from those responding to the survey).

Several of the barriers were similar to those mentioned for the police, including:

Shame, stigma and concern about not being believed

As with the police, many respondents were concerned about the issue of the negative emotions they would feel when reporting a rape or sexual assault to health or other support services, and were also worried that staff may not believe them or treat them with sensitivity. Comments included:

> "There's a stigma that if you call for help or advice, you're just a bored middle aged housewife looking for attention, with nothing better to do."
>
> "You feel disempowered, ignored, stereotyped and pre-judged."
>
> "I'm not sure I'd be comfortable enough to say, even if it was a health professional, rather than the police."
>
> "You just feel shame, fear, maybe you're in denial, and it's embarrassing to go to a health service and try to tell someone what has happened to you."
>
> "It only takes one person to suggest that maybe you asked for it, or somehow you were responsible, and the trust is gone."

Gender of staff

As with the police, another barrier mentioned was the gender of staff available to see victims in health settings, with particular concern about the gender of those conducting forensic examinations.

In addition, some people raised concerns that sexual assault services exclude men or assume "all men are the problem" which discourages men from seeking help. In addition, some respondees felt that generalisations about me over-simplify complex issues and do not recognise that women can be perpetrators as well as victims of assault.

Concern about confidentiality and privacy

One of the main barriers mentioned by those we consulted with was concern about the confidentiality and privacy of accessing health or other support services for those who have been victims of sexual assault or rape. Several reported they thought

hospital-based health services, including Accident and Emergency, would be obliged to inform their GP or that any NHS service would automatically inform the Police if someone sought health services following a rape.

Respondents were concerned about being seen accessing these services, having to explain why they were there in public reception areas, and of the risk of family finding out they were accessing these services. Typical comments included:

> "Your family could find out if something arrived in the post from the service."

> "There is no privacy in some of the places you have to go – like hospitals, they are always very open at reception, and other people can hear why you are there when you are speaking to staff."

> "You can't speak openly, you don't feel secure, it should be in private."

> "I don't feel comfortable in a crowded place, having to wait with lots of other people."

A number of respondents were concerned that they could see people they know working at health services or other support services for victims of sexual assault or rape, and this would prevent them from accessing these services.

For a small number of respondents there was also concern that the incident would go on their medical records.

Trust issues, being exposed and reaction of family and friends

As with the police respondents had a number of concerns around the issue of trust, and whether disclosing to health services may result in other people finding out that they have been the victim of sexual violence.

It was also suggested that some young people do not access health services for victims of rape or sexual assault because they are concerned that their parents will automatically be informed and the authorities (police, social services) involved.

Respondents were fearful of the reaction of family and friends if they found out that they had been the victim of sexual violence. One respondent commented that they had lost a whole friendship group because they had reported a sexual assault.

> "I lost a whole group of friends after reporting someone who had sexually assaulted me, because the man was part of that group, and they all sided with him."

There were also a number of barriers mentioned which were more specific to health services. These were:

Fear of being pressured to report to police

For some respondents a barrier to reporting to health services was a fear that if they did that they would then be pressured to report to the police, even if they themselves were not keen on this. As one respondent said:

> "I'd be worried that there would be pressure on me from them to report it to the police."

Limited expertise in dealing with younger people

One respondent suggested that another barrier to reporting to health services is there limited expertise in dealing with young people. While they felt that NHS staff are more used to this than the police, there is still limited specialist services for younger victims of rape and sexual assault.

Opening hours, waiting times and location of service

There were a number of practical issues which respondents suggested could act as barriers to accessing health and other support services for people who have been raped or sexually assaulted. These included the opening times of services, waiting times to be seen, the time taken to get an appointment, and the location of the service (how easy it is to access using public transport).

> "Waiting times, and having to sit around waiting with other people, that puts me off."

> "It took a week for me to get an appointment for a medical examination, that's too long."

> "The opening hours need to be convenient."

> "You need to be able to get there easily, if you have to get public transport it should take you there, but you don't want it to be obvious what service you are going to."

Lack of awareness of services available

Another potential barrier mentioned by those we consulted with was a lack of awareness of the services available for victims of sexual assault and rape, and services that were likely to be friendlier towards certain groups, such as the LGBT community or sex workers.

> "I'm just not sure where I would go, I wouldn't know where to look."

> "There's a lack of knowledge of where to go to access services in confidence, particularly as an LGBT individual."

Poor after-care, follow-up support, referral to other support agencies

For a number of the respondents that we consulted with, another barrier to reporting rape or sexual assault to health services was a perception that health services for victims of sexual violence are not particularly good at providing adequate support after any initial treatment, and that there is insufficient onward referral to other support services to provide long-term support to victims.

> "They do not follow up with the patient after seeing them, when they are 'well', to check how they are."

> "The staff are not picking up the issues and referring on to the relevant agencies."

One respondent felt there was insufficient availability of counselling long-term.

> "There's not enough services for counselling, I am still waiting for my appointment."

4.3 SUGGESTIONS TO ENCOURAGE MORE PEOPLE TO REPORT RAPE OR SEXUAL ASSAULT

Having discussed specific barriers to reporting rape or sexual assault to both the police and health services and other support services, those that we consulted with were then asked for suggestions of things that could be done to encourage more people to report rape or sexual assault. Their suggestions can be grouped into the following key areas:

- Legal System
- Services in general
- Police and CPS
- The SARC
- Publicity and education
- Other.

Legal System

The individuals and organisations that we consulted with during the research had a number of suggestions of ways in which the legal system could be improved for victims of sexual assault and rape.

The most pressing issue mentioned was the need to improve conviction rates for rape and sexual assault, with the low level of convictions sighted as a real barrier to people considering reporting sexual violence.

> "The real problem is the conviction rate – it's so low, it just means you have no confidence in the legal system."

> "It seems set up not to give you justice."

> "They need to educate juries about rape myths."

Another suggestion was that victims should not have to give evidence in from of perpetrators or their families in court.

> "You shouldn't have to give your evidence in front of the person who has raped you, or their family. It's traumatic enough without that."

One organisation stressed that the recommendations from the Stern Review need to be implemented, as do those from the Forging Links report, and they also suggested that there should be dedicated Police Rape Investigation Teams and a Rape Scrutiny Panel.

Another respondent suggested that rape and sexual assault cases should be fast-tracked through the court system, so that victims do not have to wait a long time for their case to get to court.

> "Why can't they fast-track the cases? People are going through the most awful stress waiting to find out what is going to happen, their relationships are falling apart – they need to know what is happening so they can try to move forward."

Finally a number of respondents suggested that there should be more support for victims who are going through the legal process.

> "There should be more support for people going through the system, so you are not left to deal with it all by yourself."

Generic Services

While respondents had a number of specific suggestions to improve services offered by the police and the NHS, there were a number of suggestions which applied more generally to all local statutory services.

Respondents suggested that all agencies need to have staff that are better trained to be sympathetic to victims of rape or sexual assault, and who are able to deal with disclosure of sexual violence appropriately.

They felt it was vital that the first professional someone discloses to be able to deal with the issue in an appropriate, calm, relaxed and compassionate way, ensuring the privacy of the victim is respected, they are taken to a safe environment, and the victim is empowered to make a choice about what to do next.

> "It shouldn't matter who the first person you tell is – if they are a professional in the police, or the health service, you should get the same sensitive service and feel believed. Without this the trust can go instantly."

> "The first person a victim sees needs to respond appropriately, give them back some of the control and power they feel they have lost."

> "First impressions count a lot, so the first person you speak to has to get it right."

A number of respondents also suggested that public services in general need to improve the cultural awareness of staff, so that they are better able to deal with people from various diverse communities.

> "All staff should have diversity training, and they should be used to dealing with people from a wide range of backgrounds, and with a wide range of issues. No one should feel they are being discriminated against, for any reason."

> "Ideally you want a range of staff from different cultures, who are able to relate to other cultures, and even speak their language. That might not always be possible, but it should be encouraged where possible."

Linked to this, a number of staff from organisations working with people with mental health issues suggested that more staff need to be trained in mental health issues, so that they are able spot mental health issues that service users may have, and respond appropriately to these.

> "Agencies who may be referring people to the new SARC need to have staff who can cope with disclosures from people with mental health issues. Often these people can be challenging to work with, and if staff are not trained to recognise mental health issues these people may miss out on the help they need, and are asking for."

Police and Crown Prosecution Service (CPS)

There were a number of suggestions of improvements that both the police and CPS could make to encourage more people to report rape and sexual assault.

The first was that the police and CPS should improve their communication with victims of sexual violence who have reported the crime, including assigning a designated contact within the police or CPS who will inform a victim about the progress of their case at regular or agreed intervals.

The importance of a supportive and well-informed response from the first police contact people speak to was emphasised as being essential. Several respondents suggested the option of speaking informally to a specialist officer about the process of reporting would help people to understand the process and be more confident to make a formal report.

Linked to this a number of respondents suggested that victims should be assigned a key contact in the police, who will be responsible for communicating with the victim, and that victims should be able to have the option of having someone of their choosing there to support them through any meetings with the police (e.g. when giving a statement).

> "You should be able to see the same person when you go there, or when they contact you, so you have some sort of relationship with the person, you build some sort of rapport."

> "When someone is involved with the police they should have the option at all times to have someone who gives a dam or who will empathise with them at every interview."

Respondents also felt strongly that there should be an improvement in the way that victims are informed when their case is not going to be taken to court, with the police or CPS taking time to explain the decision properly.

> "The CPS general manager was never available to speak to, we were never able to find out what was happening with the case."

> "The CPS should have targets to meet on the victim experience. It seems like they are the last concern sometimes."

> "Someone we were working with found out weeks after the CPS had decided not to prosecute, because they had just told the social worker, rather than making time to speak to the victim. The victim felt that the police had disbelieved her story because no one from the police or the CPS came to explain what had happened properly."

> "People just get a phone call from the CPS to say nothing is going to happen – the least they could do is come and meet a victim face-to-face to explain why the case is not being taken forward."

One respondent also suggested that victims should have easy access to protective custody if they are concerned for their safety. As they said:

> "The police should make it clear that they can offer you protection if you need it, for you and your family, protective custody, if you need it."

Another suggestion was around the issue of gender of staff, with respondents suggesting that wherever possible victims should have a choice about whether they are comfortable with a male or female police officer dealing with their case (in whatever way).

> "There should really be a choice of gender of the officer you see, particularly as many people would be uncomfortable with a male police officer."

A number of organisations that we spoke to suggested that the role of Independent Sexual Violence Advisors (ISVAs) should be better publicised within the police and that more use of their services should be taken up by police officers dealing with cases of rape and sexual assault.

> "Some police officers do use the ISVAs, and find them very useful, but there is still resistance or ignorance about their role among some officers, and that needs to be addressed."

Finally a number of respondent suggested that the police need continuing training from specialist providers so that frontline officers remain/become more sympathetic to victims of sexual assault, and are better trained about how victims of sexual violence may present themselves (e.g. ways in which trauma can present itself, such as lack of emotion, laughter).

> "Some police are great, but there are still a large number of frontline officers who are not used to dealing with victims of sexual violence. They don't understand issues around trauma, and how this can affect victims. They may see someone laughing during a forensic examination and assume they are not serious about the allegation. They don't understand this can be a reaction to trauma. Police need specialists who are used to working with victims of sexual violence to provide adequate training to as many frontline officers as possible."

The Sexual Assault Referral Centre (SARC)

There were a large number of suggestions and ideas to make the new SARC as good a service as possible, and to encourage more people to report rape and sexual assault.

The first was that the SARC should be a safe environment which is easily accessible in a discreet way, so that victims who are going there can do so in private. Respondents also suggested that it would be easier to go to a SARC than the police, so ideally they should be able to report to the SARC and have the police come there if the victim wants to report to the police.

> "It would be easier going to a centre than the police, and if you are more confident having been to the centre, then they can liaise with the police and they could come to you, rather than having to go to a police station."

> "It should be in a hidden place, but easily accessible, so you can go to a safe environment and not worry about being identified."

Some respondents also suggested that the SARC should act as a single centre/service where victims can access other local services including the police (if they want to report), social services, counselling, forensics, GUM, links to safe housing and other services.

> "It would be good if you only had to go to the SARC, and you could access the other services you need there, like GUM, forensics, counselling, social services, links to housing support, and the police if you want to report."

One of the key recommendations that respondents had, and that the organisations we spoke with were very keen to stress, was that the SARC must be very explicit about what services it is able to offer and to who, what people can expect when they go to the SARC (in terms of the process, and the level of care/service) what their rights are and what the limitations of the SARC service are, so that victims are clear even before they contact/attend the SARC about what services and support they can expect there.

> "There is a danger that the SARC could be flooded with people wanting support and help if people think they are there to do everything. They need to be very explicit, in ways that people will understand, about what they are there to provide, what support they can give, and where people should go for support that is not offered by the SARC."

> "They need to set out what the service is for, who it is for, in a simplistic way that everyone can understand."

> "Don't promise things that you are unable to deliver – there's no faster way to taint the reputation of a service."

> "They need to make it explicit that they are welcoming to everyone, specifically say there will be no discrimination for LGBT people, EMG communities, sex workers, people with learning disabilities, you name it, they need to say it, otherwise people will still be concerned about using it."

A number of individual respondents and several of the organisations that we spoke to recognised the potential for the SARC to signpost to other suitable support services for victims of sexual assault and rape, where the SARC is not the most suitable service, but they stressed that this would require the SARC to have excellent links to other local services (including the voluntary sector), with up-to-date information, so that people were not signposted to the wrong place.

> "Potentially the SARC could become the first point of contact for the majority of victims, depending on how it is promoted and what people hear about it. This means they will have a vital role in dealing with people who may not actually need the services provided by the SARC. They must ensure that these people are handed on to other suitable support services, and are not left to fall through the gap, or get lost when they are signposted on elsewhere."

> "There are already specialist sexual violence support services doing excellent work in the area – the SARC should not be looking to take over from them, but instead develop excellent links with them, so people can be referred/signposted to these services if they are more suitable."

> "The SARC should be publicising the range of other support services which are out there, making links with/to the voluntary sector."

There was also a suggestion from a small number of those that we consulted with that it would be a good idea to have a preliminary meeting with victims to explain to discuss with them what their options are, what support the SARC could offer them, what their other options are, and allow them the chance to consider these choices before they decide what route to go down.

> "Sometimes people can be rushed through things, and obviously there are forensic windows to consider, but it might be an idea to have an initial meeting to explain what the SARC does, what other support is available, and the option of reporting to the police, so that victims can think about what would be best for them."

Another suggestion made by a number of respondents was that victims should be assigned a key worker at the SARC who can act as the main point of contact in any communication between the victim and the SARC, will support them through the process of attending the SARC, and will arrange any onward referrals to other support services (e.g. counselling) or involvement of the police.

> "It would be good to assign a key person who will accompany the victim through the whole process of attending the SARC, who will be a consistent supportive presence through the process, and will help to arrange what happens next."

Respondents were also keen that staff at the SARC have suitable knowledge and expertise in dealing with a wide range of service users, including those with mental health issues, learning disabilities and victims of domestic abuse, so that the service is as accessible as possible for everyone in the community.

> "If the SARC is really going to be accessible for everyone then they need staff who are trained to work with people with challenging issues, such as mental health issues, or people with learning disabilities."

It was also important for a large number of those that we consulted with that there should be a choice of gender of staff that victims see when they attend the SARC. In the majority of cases this particularly applied to being able to see a female rather than a male, however ideally there should be the provision for a victim to see a male member of staff if they were more comfortable with that.

> "There should be a choice of the gender of staff that you see, male or female."

> "It should be the victim's decision about the gender of the staff that they see."

A number of respondents were also keen that there should be staff at the SARC (or as suggested by two respondents volunteers) with direct experience of sexual assault or rape themselves, so that victims are able to talk to someone with real insight into what they are going through.

> "There should be people who have real insight from their own experiences in life, who can support individuals who are going through a similar process."

> "Perhaps they could have staff or volunteers with similar experiences who can give you support. You have to get people in there with similar experiences as it means there is some mutual understanding and trust there."

For respondents from EMG communities, and staff from a number of the organisations that we spoke with, it was suggested that ideally there should also be staff at the SARC who are able to speak in different languages, particularly those of local EMG communities.

> "There should be staff at the SARC who you are able to talk to in your own language, it would make it far more comfortable and easy."

> "It would be good if they could speak your language."

Where this is not possible it was suggested that there should be translators readily available, but that great care should be taken in how these translators are appointed and trained, to ensure they provide a proper service, and do not risk breeching the confidentiality of service users. It was suggested that it would be better if they were recruited from out with the local area, so they are not from the EMG community that victims are from.

> "You need to be very careful where you recruit translators from, so that victims are not compromised in their communities. They need to be vetted to make sure they understand the sensitive nature of their role, and ideally it would be better to recruit them from outside of Coventry and Warwickshire BME [Black Minority Ethnic] communities."

Another suggestion was that victims reporting to the SARC should have no waiting time for emotional support and/or counselling services. It was felt that those accessing the SARC should be immediately provided with these services. As one respondent commented:

> "People going to the SARC are so vulnerable – they need the support there and then, not have to wait for a few weeks to get it. There should be immediate emotional and counselling support available."

Linked to this a small number of respondents suggested that there should also be some form of support for family members who are also impacted by the rape or sexual assault of their partner or family member. As one respondent said:

> "My girlfriend, who was pregnant with my baby, she was raped, and we lost the child. It was all terrible, and worse for her, but there wasn't really any support there for me, now that I think about it. I was just expected to cope on my own."

There were also a number of suggestions for ways in which the SARC could maximise its reach and impact. These included providing drop-in sessions, having a text-in service so people can arrange an appointment time, providing a free advice helpline for victims (and possibly professionals who have questions about what to do when they suspect someone they are working with has been a victim of sexual violence), providing web-based information and support, and having mobile drop-in sessions at places such as universities, where people can come and talk to SARC staff about sexual violence issues, and short counselling sessions with advice and guidance are available.

One practical suggestion raised by one respondent was that victims are sometimes given paper suits to wear after a forensic examination (where their clothes are required as evidence). They commented that this can be degrading for the victim, and that they should be provided with proper clothing. As they said:

> "They provide paper suits for people after their examination, and they're supposed to go home in that – it's degrading for them, and not exactly inconspicuous. They should be given a choice of some normal clothes which they can wear after the examination."

A final recommendation was around the role of ISVAs, and how they could be better utilised. Respondents who were aware of the ISVA service all felt that it is a vital service, with the ISVA providing an important link between the victim and the services they access, including the police, and offering emotional support through this process. These respondents were keen to see the role of the ISVA publicised more, and for there to be automatic provision of ISVA support for anyone reporting to the new SARC. Comments included:

> "There should be 100% referral for victims of sexual offences to ISVA support."

> "There should be publicising of ISVA support at all points of reporting, and better funding for this role."

> "They should publicise the ISVA role and make it accessible and available out of hours so that victims can be better supported at such a vulnerable time."

Publicity and education

One of the most consistent suggestions that respondents had was for the need to publicise the new SARC service effectively, and to educate the public about issues around rape and sexual assault more fully.

There were a wide variety of suggestions of ways in which the new SARC should be promoted. These included:

- Providing information in community meetings
- Information leaflets
- Web-based advertising – potentially including targeted advertising on Facebook, e.g. with young women/teenagers, students etc.
- Social media presence (twitter, Facebook etc.
- Publicity on buses, in taxis
- Development of a mobile app (e.g. nearest sexual health centres/support)
- Radio advertising campaigns
- Awareness raising with voluntary sector and targeted promotion to those organisations working with vulnerable people and minority communities
- Awareness raising in health settings (GPs, hospitals, domestic violence services, dentists, community health centres)
- Promote through Learning Disabilities Partnership Boards
- Workshops and promotion in schools (pupils and staff), youth groups, colleges, workplaces
- SARC involvement in SRE in schools, possibly allow school trips to visit the SARC to promote service and raise awareness of issues
- Promotion to Parent Partnerships
- Having an easy telephone number to remember
- Producing products with SARC telephone number and website on the (which would appeal to target audience)
- Accompanying other campaign groups/campaigns
- Having a campaign targeted specifically at males

A number of respondents also suggested that the new SARC would benefit from having outreach workers, particularly to work with EMG communities, but also other groups including the LGBT community, sex workers, those with learning disabilities and mental health issues and men. The role of outreach workers was seen as particularly important for the EMG community because of literacy issues, particularly among women, which would make information and literature on the SARC, even if provided in the right language, of limited effectiveness. One organisation with experience of doing outreach work in EMG communities commented:

> "Word of mouth is so important in these communities, particularly among women, who often have literacy issues. You need to go to meet with community groups, speak to women in environments where they feel safe and able to talk about issues, and you need to tell them about services. That's the best way to let people know about services, and to educate them about their rights."

Those that we consulted with also suggested that there needs to be a wider effort to educate the public about the issues around rape and sexual assault, in order to dispel some of the myths and stereotypes around the issue, and to raise awareness about the rights of victims.

There were a wide variety of suggestions of what this education and awareness raising should include, and how it should be delivered, including:

- Encouraging people to talk more openly about the issue
- Being non-threatening and not too full-on
- Providing hard facts on conviction rates
- Giving a clear message to victims that it is not their fault, and that coming forward can begin the process of getting their life back
- Education around the issue of consent, and reinforcement that this still applies to people in relationships
- Changing societal attitudes of victims being to blame (e.g. because of what they were wearing, or being drunk)
- Education on what sexual violence is

A number of people that took part in the research also felt that reporting and portrayal of sexual violence in the media has a negative impact on attitudes on rape and sexual violence, and that there should be a concerted effort to change this.

> "The media need to be encouraged to report more positively, so if someone is convicted of rape, that should be news, not just the rape itself."

> "There need to be more positive stories about people surviving sexual violence, the support that is out there, and that the legal system can work."

> "The media have a role to play in educating people in everyone's right to be safe sexually."

> "Recently there were storylines about rape in both Hollyoaks and Coronation Street, and in both the men were not convicted – we need to challenge the media and encourage them to take a more pro-active role on this issue."

For a number of respondents this extended to a need for campaigns on a national level. Typical comments included:

> "We need further national campaigns raising awareness and educating people on what support and protection is available."

> "People need to be educated nationally about what sexual violence is."

> "We need more positive campaigning, like Scotland's 'short-skirt' campaign, I think that was quite successful."

5 ISSUES FOR PARTICULAR GROUPS

In this Chapter we examine the issues that were particularly prevalent or specific to the various diverse groups of:

- LGBT communities
- Ethnic minority groups
- Men
- Sex workers
- Adults with learning disabilities
- Adults with mental health issues.

5.1 LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) COMMUNITIES

Barriers to using general local public services

The LGBT people who took part in our research mentioned a number of factors specific to their community which they felt could act as barriers to using local services in general. These included:

- Concern over being discriminated against because of their sexuality or gender identity
- The issue of gender preference regarding medical staff (e.g. requesting a female doctor), and whether health services would be sensitive about this
- Concern about confidentiality and privacy, in particular people finding out about their sexuality or gender identity
- Feeling that the police can be homophobic and discriminatory or insensitive towards the LGBT community
- Finding it difficult to locate services which are specifically for LGBT people, or are LGBT friendly, or have the relevant knowledge, skills and sensitivity to work with LGBT people
- A sense that frontline staff in the respective public services do not always have/know about the information and/or services available for the LGBT community, and in some circumstances do not come across as very 'nice' to the LGBT community.

Barriers to reporting rape or sexual assault to the police

In addition to the barriers highlighted for using general public services, those that we consulted from the LGBT community mentioned a number of specific barriers which may discourage LGBT people from reporting rape or sexual assault to the police. These included:

- A fear of not being respected by the police, not been taken seriously, or not be believed because you are gay
- A perception that you may face negative attitudes from frontline staff as an LGBT person

- Concern that nothing will be done about a reported rape or sexual assault, or that you will not be believed as a gay person
- Concern that your sexuality will become public knowledge
- A fear of going to court and previous sexual partners, sexual history or sexual identity being dragged up, and the repercussions this could have
- Lack of choice of gender of officer that you report to.

Barriers to accessing health services and other support

There were also a number of specific barriers which the LGBT people we consulted with suggested may discourage them from accessing health services if they have been raped or sexually assaulted. These were:

- Concern about confidentiality and privacy issues, including that their sexuality may be revealed, and that family or friends may find out
- Fear of what people will think or how they will treat you as an LGBT person
- A worry that seeking help may result in intrusive medical examinations which they do not want
- Not wanting to have to see a certain gender of staff, particularly when speaking about such a sensitive issue
- Having to talk to someone about their sex life who is not themselves LGBT.

Other barriers

Other factors which LGBT respondents mentioned as possible factors that would prevent them from going to the police or NHS if they had been raped or sexually assaulted were:

- A belief that if it happened in a relationship they would not be taken seriously
- Not wanting to go to a service where they may know some of the staff.

Suggestions for improving general local public services

The LGBT respondents to the consultation had a number of suggestions of ways in which general local services could be improved to make them more welcoming for LGBT people. These included:

- Clear positive messages welcoming LGBT people, with public services acting as leaders for full equality
- Staff who are sensitive and empathetic towards LGBT people
- Clear standards that you can expect from a service, no matter your sexual orientation or gender identity
- A choice about the gender of staff that you see for appointment (particularly medical appointments, but not only limited to those)
- Staff at all general services should be able to sign-post to more specific LGBT services and information
- Services should be promoted more effectively in LGBT friendly places.

Suggestions to encourage more people to report rape or sexual assault

The only suggestion to encourage people to report rape and sexual assault specific to LGBT respondents was to have more campaigns and promotion of the support available specifically for LGBT victims so that the community knows that help is there, and that LGBT people will be supported.

5.2 ETHNIC MINORITY GROUPS

Barriers to using general local public services

The EMG respondents who took part in our research mentioned a number of factors specific to their community which they felt could act as barriers to using local services in general. These included:

- Language barriers – both in terms of information available and staff able to speak their native language
- In part as a consequence of language barriers, EMG communities are often less informed about what services are available, where and when.

Barriers to reporting rape or sexual assault to the police

In addition to the barriers highlighted for using general public services, those that we consulted from EMG communities mentioned a number of specific barriers which may discourage EMG people from reporting rape or sexual assault to the police. These included:

- Language barriers
- Not having information about the process for reporting a rape or sexual assault or the support available (possibly due to lack of translated information)
- Cultural and religious factors which mean that:
  - women are not used to coming forward to the authorities
  - many women are afraid of their husbands, family and society
  - the whole family will often become involved – police can be insensitive to this and will talk to the whole family rather than the victim themselves
  - there is often resistance to involving the police at all
  - women feel particularly ashamed and embarrassed about having been raped or sexually assaulted
  - there is real concern about the shame that an accusation could bring to a victim's family and the community as a whole
  - the community finding out that someone has been the victim of rape could impact on their eligibility to marry
- Women being afraid of being disowned by their family (and in some cases being concerned for their lives (that they may be a victim of so called 'honour killing').

Barriers to accessing health services and other support if you have experienced rape or sexual assault

There were also a number of specific barriers which EMG people we consulted with suggested may discourage them from accessing health services if they had been raped or sexually assaulted. These were:

- Language barriers
- Not having information about health services that could help if they wanted to report a rape or sexual assault (possibly due to lack of translated information)
- Being particularly ashamed and embarrassed about having been raped or sexually assaulted
- Cultural and religious factors meaning they are particularly embarrassed about intrusive examinations, and may be very reluctant for these to be conducted by a particular gender of health professional.

Suggestions for improving general local public services

The EMG respondents to the consultation had a number of suggestions of ways in which general local services could be improved to make them more welcoming for EMG people. These included:

- Providing translated publicity material (posters, information leaflets, online) for people whose first language is not English
- Awareness raising within EMG communities of the services that are available
- Providing staff who are trained to be more culturally sensitive and aware (or have more staff from EMG communities).

Suggestions to encourage more people to report rape or sexual assault

Respondents from EMG communities had a number of suggestions to encourage more people from these communities to report sexual assault and rape.

One of the main suggestions was the need for more education and awareness raising within EMG communities, about the issues of consent, rape and sexual assault, the process for reporting an offence, and the support available for victims. As various respondents commented:

> "The issue requires frank discussion. There is a problem in certain ethnic communities, around sexual violence, and it needs to be raised."
>
> “The BME issue is very hard to tackle, but needs education, awareness raising, strong messages, and punishment for those caught.”
>
> “To tackle this issue you need political will, and that will only come from engaging those in powerful positions in these communities, educating them

and getting them onside. You need to engage male elders in BME communities, explain the issues to them, educate them."

"There is an issue with different understandings of consent between British born BME and those who have come over from other countries."

Respondents had a number of suggestions for ways in which awareness could be improved in EMG communities, and attitudes challenged. These included:

- Encouraging communities to talk more openly about these issues
- Having outreach workers or SARC staff attend community group meetings
- Providing translated information about SARC services
- Providing education in schools and colleges
- Outreach work and publicity in:
  - Mosques (e.g. at Friday prayer), Sikh Temples, Churches
  - Asian Women's Groups, Muslim Resource Centres, Women's Institutions.

EMG respondents also had a number of suggestions for ways in which services for victims of sexual violence could be more welcoming for people from EMG communities. These included:

- Having staff working in these services who understand the culture of various EMG communities, and/or speak the language of various EMG communities
- Having translators available (where staff are not able to speak same language)
- Reassuring women about issues of confidentiality, and ensuring services are accessible in private
- Police having more EMG officers and better links to EMG community groups and projects
- Providing staff with training to raise cultural awareness of issues for EMG victims.

5.3 MEN

There was anecdotal evidence from both CRASAC and ROSA that they are seeing increasing numbers of men come forward about being victims of sexual assault and rape, although the reasons for this increase have not been examined.

Barriers to reporting rape or sexual assault to the police

The men that we consulted with during the research mentioned a number of specific barriers which they felt could discourage men from reporting rape or sexual assault to the police, including:

- Shame about being the victim of sexual assault, of losing your 'masculinity'
- A perception that, as a man, you will not be taken seriously, or that you will be looked down on

- Fear that reporting will lead to disclosure of what has happened to you to family and friends, that it will become public knowledge
- Concern, particularly among gay men, that if you have previously been promiscuous, if you have been drinking or using illegal, or you have been engaged in 'risky' sexual behaviour, you may not be taken seriously
- Fear about the attitude of frontline officers to a man having been the victim of sexual violence
- A lack of choice about the gender of officer that you are able to report to (most men who commented on this said they would prefer a female officer).

Barriers to accessing health services and other support if you have experienced rape or sexual assault

There were also a number of specific barriers which the men we consulted with suggested may discourage them from accessing health services if they had been raped or sexually assaulted. These were:

- Not being able to request a specific gender of health professional, particularly for forensic examinations
- Concern that you will not be taken seriously or looked down on as a male victim
- Some services being geared towards or only for women.

Suggestions to encourage more people to report rape or sexual assault

Male respondents had a number of suggestions to encourage more men to report sexual assault and rape. These included:

- Acknowledge that the experience is different for male victims of sexual assault
- Providing staff with specific training on the impact that rape and sexual assault can have on men (CRASAC have done specific male impact training for all staff and volunteers and may be able to supply this)
- Provide a choice of gender of staff that men can speak to – many may prefer to speak to a female, however some may welcome the opportunity to speak to a male who has experience of the issue or has the relevant expertise
- Provide sources of information for male victims.

5.4 SEX WORKERS

We spoke with a number of organisations that work with people who sell sex, and there were seven survey respondents who identified themselves as people who sell sex. There were a number of specific issues which this group highlighted, including:

Issues with the police

- There is a perception among this group that the police will pre-judge them because of who they are, and that they will not be treated with dignity or respect, and that people will have an attitude of them having 'brought it on themselves'
- This group have particular fears that coming forward to the police could result in them facing trouble for selling sex
- Similarly many people within this group have problems with drug and alcohol misuse, and fear that the police may take action against them for this if they come forward to report a rape or sexual assault
- They are also concerned that their complaint will not be taken seriously if they are involved in selling sex, or they are known to the police for that already
- There was some concern about the consequences of withdrawing a complaint at a later stage of the investigation, and how this may impact on the police's attitude to a victim in future (e.g. in relation to being a known sex worker).

Other issues

- Respondent who were involved in selling sex were also concerned that if their case went to court they could be exposed to friends, family and the public as a sex worker
- The role of the ISVA was seen as having a vital role to play in acting as a link between a victim who is a sex worker and the police.

5.5 ADULTS WITH LEARNING DISABILITIES

The organisations that we met with who work with adults with learning disabilities were particularly concerned about the vulnerability of their service users to inappropriate sexual relationships, sexual exploitation and grooming.

Staff commented that they were aware of a significant number of service users who had been in what they would view as sexually exploitative relationships, including some who had been raped in their relationships.

They also said they were aware of young women with learning disabilities being targeted and groomed by older men, often using the internet (they were aware of people identifying these women by searching for people who had attended the local special needs school). While these vulnerable women may have been over the legal age of consent, staff at these organisations said they often look younger, and have a significantly younger mental age.

> "These are very controlling relationships, with men or groups of men targeting these women, they have a trail of relationships, often targeting them Facebook, looking at people who have been to the special school in the local area."

The staff said they are very concerned about this phenomenon, and they are concerned that it is increasing. One of the main issues is that people with learning disabilities often do not perceive themselves to be in an exploitative relationship, and they are so keen to have what they see as a 'normal relationship' that they are very open to forming relationships. They are also more used to not having much control and being told what to do, so they are more easily exploited.

The organisations that we spoke to were also critical of other professionals for not examining these relationships to see whether they are appropriate, or assuming that these people are able to decide what a good relationship is.

They acknowledged that these are challenging issues for professionals to deal with, considering the legal age of consent, and determining what an appropriate relationship is, but they felt there should be more awareness of this as an issue. As one commented:

> "For the police there is an issue that these people have consented, so they are not able to do anything, but there is an issue about their capacity to consent. The police are receptive to complaints from people with learning disabilities/their support workers, but they are in a difficult position regarding consent and the fact they are over age (despite possibly having younger mental age)."

Barriers to reporting rape and sexual assault

Staff from organisations working with people with learning disabilities suggested that particular barriers may include:

- People with learning disabilities not viewing themselves as victims
- Concern that no one will believe them
- Feeling (or being) unable to report without support
- Needing a lot of patience and reassurance
- A lack of appropriate referral routes for staff concerned about the relationships that service users are in
- Attitudes of frontline staff and officers, such as blaming victims, making jokes about them and judging them
- Police having no idea how to speak to someone with higher support needs, and treating them like anyone else when taking a statement
- Staff in care homes starting to investigate allegations or concerns themselves, rather than using proper Safeguarding procedures and police investigation.

One organisation also had a particular complaint that when they had supported a service user through reporting historic sexual abuse, the police and CPS had been very poor at keeping them informed about progress in the case, did not respond to any emails or calls from support workers trying to find out what was happening, and then when it was finally decided that the case would not be pursued due to lack of evidence the police and CPS informed a social worker, rather than the victim, and it

took some time before they actually found out the case was no longer being investigated. As staff from the organisation explained:

> "There was no proper explanation given for why this had been decided, or who had decided it. The service user was upset and worried that various people didn't believe her story, that the police thought she was a liar."

Staff from the organisation felt that there should have been someone official (from the CPS or the police) to explain in person to the victim what had happened and why the outcome was as it was, so they at least had some sense that they had been believed.

Other issues

The organisations working with people with learning disabilities were largely unaware of existing support services for victims of sexual assault and rape in Coventry and Warwickshire, and said that any new service should ensure that it is properly promoted to organisations such as themselves, so that they know where they can get support and advice from, and where to make referrals to if they need to.

Other issues raised in relation to people with learning disabilities included:

- A lack of proper sex and relationship education for people in special schools
- No support for people with learning disabilities to use social media safely
- A real taboo among professionals of talking to people with learning disabilities about sex and their sex lives
- A lack of expertise in health and other services for dealing with young people with learning disabilities who are starting to have sex, or are interested in sex, with staff seemingly unable to even talk about the issue
- There is an expectation that these people will live 'independently', but support staff are not comfortable with them having a sex life.

Suggestions to encourage more people to report rape or sexual assault

Staff from the organisations working with people with learning disabilities had a number of suggestions to help people with learning disabilities be enabled to report rape and sexual assault. These were:

- Have a meeting of all key workers at the start of the process to get a broader perspective on the victim and make a plan to support them during reporting and potential case
- Training police to work with people with learning disabilities, or providing people who are specialists in this to help with taking police statements
- Showing real patience and giving time for people to give an account of what has happened (it can often take a significant amount of time to establish a dialogue)
- Understand that people with learning disabilities often have a lack of understanding of times and dates

- Explain the process very simply and clearly, so that people with learning disabilities know what to expect, and what their choices are
- Explain the difference between the police and the CPS, and what their different roles are
- Provide a helpline that agencies can call if they are concerned about something or are aware of cases where someone may be in a vulnerable position, even if the person does not want to report it or does not want help
- Allow victims to be accompanied by the most appropriate person (e.g. support worker, carer)
- Give people with learning disabilities the option of talking in the third person
- Properly debriefing the victim and key support staff whatever the outcome
- Make it easier for support staff to liaise with the police - let them know who to contact, when/where to go for information.

Physical environment of the SARC

The staff that we spoke with from organisations working with people with learning disabilities also had a number of suggestions about the physical design of the new SARC, and how this could best meet the needs of people with learning disabilities. Their suggestions included:

- Proper facilities for people with learning disabilities
- Having a bespoke approach appropriate to need
- Good access points and comfortable
- Not being to 'clinical' in appearance, or have an 'officious' approach
- Having individual rooms for people
- Ensuring there are hoists for physical examinations
- Being aware that people with learning disabilities can be very susceptible to light and noise
- Ensuring that signage is very simplistic and clear, and avoid lots of words
- Having a real face-to-face service
- Recognising that 'signing-in' at reception can be difficult for people with learning disabilities
- Have text reminders for appointments where this would be useful
- Have somewhere quiet to sit outside, with space in nice surroundings
- Make it look like an ordinary building, and avoid it being labelled
- Take away the stigma of the building and service
- Have a TV on in the waiting area, and a coffee machine – try to make it relaxing.

5.6 ADULTS WITH MENTAL HEALTH ISSUES

Barriers to reporting rape and sexual assault

The respondents with mental health issues (or people working with adults with mental health issues) who took part in our research mentioned a number of factors

specific to people living with mental illness which they felt could act as barriers to reporting rape and sexual assault may include:

- Fear of responses to disclosure - expecting that they will be pre-judged on their mental illness and that this will override the validity of the complaint about the rape or sexual violence
- Reporting can lead to a chain of events which feels out with the control of the victim and is in itself distressing
- Concern that as someone with mental health issues you will be considered unreliable, thought to be making up stories or 'attention seeking' and not believed
- A lack of emotional support on offer, and limited understanding in some services of the complex psychological consequences of rape
- Some professionals not being confident in dealing with people with mental health issues
- Some mental health professionals not being confident or skilled in dealing with issues of sexual health or sexual assault
- The trauma of the investigation and the length of time it takes from reporting to the actual court case can aggravate mental health problems.

Barriers to accessing health services and other support for those who have experienced rape or sexual assault

There were also a number of specific barriers which respondents with mental health issues (or those working with this group) suggested may discourage them from accessing health services and other support if they had been raped or sexually assaulted. These were:

- A perception that treatment (such as counselling) may be costly
- Difficult in disclosing the trauma of the event and after-effects
- Staff not picking up relevant mental health issues in victims and failing to refer them to suitable support services.

Suggestions to encourage more people to report rape or sexual assault

The respondents to the consultation with mental health issues, or working with this group, had a number of suggestions of ways in which services could be improved to help people with mental health issues report rape and sexual assault, including:

- Mandatory mental health awareness training such as mental health first aid for frontline staff, including Police Officers and NHS staff
- Provide training on mental health issues to referring agencies
- Eliminating any waiting lists for emotional support/ counselling for victims
- Providing non-threatening environments for reporting
- Having specialist staff available that are highly trained in working with people with mental health issues

- Improved and rolled out 'Appropriate Adults' training for those supporting people with mental health issues
- Informing both victims and carers/support staff about the roles of different staff and agencies in the process (Police, SARC, other support services)
- Ensure that there is support from an ISVA and/or organisations that can support someone with mental health issues when a victim with mental health issues reports
- More holistic approach to investigation and supporting victims with mental health issues in the long and short term
- Have a more personalised service where service is delivered to the user rather than the user having to go to the service
- Ensuring that staff have relevant knowledge of the support service available for people with mental health issues, and signpost to these
- Providing victims with a choice of male or female staff
- Having a named worker at the service as a point of consistent contact/reference.

Other suggestions

Other suggestions that respondents with mental health issues (or people working with adults with mental health issues) mentioned included:

- Providing people with mental health issues with assertiveness training to help them say 'No' in sexual situations, and so they understand the issue of consent
- Developing a specialist service for victims of rape to contact as first point of contact, rather than a generic 999/111 call, so that the service is specialised in dealing with rape victims.

6 RECOMMENDATIONS AND CONCLUSION

The findings set out in sections 2 to 4 above have important implications for policy and practice from national through to local levels. The researchers recognise the crucial importance of further work to improve the responsiveness of the Criminal Justice System and to raise awareness of victims' rights within it. Similarly, we recognise the ongoing need for concerted efforts to challenge the myths and misconceptions about rape and sexual assault and to raise public awareness of the services and support available to people who have been assaulted.

However, for the purpose of this report, we have focussed our recommendations on those actions that can and should be taken locally and those issues the Coventry and Warwickshire NHS, Police, and other Board members are best placed to influence. The recommendations below are relevant to the Board's commitment to improving both health and forensic outcomes for local people and have particular implications for partnership work to deliver the new Sexual Assault Referral Centre.

At the outset, MBARC committed to identifying:

- Recommendations to the Sexual Assault Strategic Board about how best to develop and tailor communications with and for specific groups to raise awareness and promote the benefits of contact with the Police and specialist services following sexual assault
- Recommendations regarding priorities and options for facilitating positive behaviour change to increase reporting of assaults to the Police and to encourage increased uptake of relevant services and support.

Based on the contributions of individuals and organisations to the research, we have identified recommendations for local consideration and action in three main categories:

- Raising public awareness and providing tailored information to local communities
- Facilitating easier access to specialist advice and support
- Providing responsive and high quality services.

Each of these is likely to have relevance to the planning, promotion, and delivery of services at the Blue Sky Centre, and additional recommendations specific to this new SARC are also highlighted.

The recommendations in the four sections below are inter-related and action in one area is likely to be mutually reinforcing in other areas. For example, success in increasing the number of people reporting assaults to the Police and seeking health services will depend on coordinated action on relevant suggestions about raising awareness of these services, ensuring they are accessible, and delivering high quality, person-centred responses.

In addition, our research highlighted the power of stories in the media or within communities to either encourage or discourage individuals from seeking protection, services or support. With this in mind, we recommend all Board members should collaborate in seeking to ensure every victim has a positive experience of local services, and in engaging local media in telling accurate stories of successful criminal justice and health outcomes rather than perpetuating negative perceptions of how public services respond to sexual violence.

It is important to note that MBARC's recommendations are drawn from this research project alone, and therefore do not include a specific focus on the experience and needs of children or young people who were outside the scope of the research. In addition, they reflect the views and suggestions of those who were willing and able to respond to the invitation to engage and have not been considered in detail against the backdrop of a local sexual violence needs assessment or analysis of local population demographics.

6.1 RAISING PUBLIC AWARENESS AND PROVIDING TAILORED INFORMATION TO LOCAL COMMUNITIES

As described in the previous sections of the report, our research identified that lack of awareness about and confidence in services is a significant barrier to seeking Police protection or NHS services. There are widely help misconceptions about how services operate and about the loss of choice and control that accessing them may generate for individuals.

We recommend the following areas are prioritised for local action and, in each case, suggest that the experience and expertise of local community organisations and trusted representatives is sought. Several of those engaged in this project expressed an interest in supporting future partnership work to tailor messages to be appropriate to diverse groups, and to promote effective dissemination of information making use of their reach into local communities.

Recommendation 1: Seek to raise awareness that rape and sexual assault can affect women, men, young people and children from every community and that victims are entitled to access Police protection and a range of services from the NHS and other local organisations.

Recommendation 2: Actively promote exiting and new services, dispelling myths about how they work and highlighting the benefits of reporting sexual assault and seeking specialist advice, support, and services to support recovery and promote criminal justice outcomes.

Recommendation 3: Develop and disseminate clear rights-based information about what to expect when reporting to the police or seeking help from health services, with emphasis on confidentiality and privacy, and on choices at every step of the pathway.

Recommendation 4: Recognise and harness the power of the local media in telling individual's stories about what happens when reporting assault or accessing services with a view to having a more positive impact on willingness to report or disclose sexual assault and to seek help.

6.2 FACILITATING EASIER ACCESS TO SPECIALIST ADVICE AND SUPPORT

Our research highlighted the need for ongoing work to clarify the respective roles of existing and planned services to ensure the best possible advice can be provided about local options for meeting diverse needs including those related to culture, ethnicity, mental illness, learning disabilities, or substance misuse. The recommendations below relate to facilitating access to current and planned services, and are not based on analysis of the coverage these are likely to provide. For example, the research did not include detailed consideration of sexual violence prevalence estimates applied to local population and demographic data, and further work on this may be required in future.

As well as issues related to limited awareness of or confidence in statutory services, respondents raised a number of important points about attitudinal and practical barriers to accessing help following rape or sexual assault. Based on the responses of individuals and organisations, the following emerge as priorities for local action to make services more accessible to diverse local communities:

Recommendation 5: Provide safe options for reporting to the Police or seeking help from the NHS, recognising that the need to disclose personal information in reception areas with limited privacy is a significant deterrent for many.

Recommendation 6: Establish a single point of telephone advice and access to sexual assault services, staffed by experts from the outset i.e. not requiring clients to go through hospital or police switchboards.

Recommendation 7: Facilitate access to a range of safe places for Police interviews so individuals do not have to attend a police station to report an assault, make a statement, or engage in other steps in the criminal justice process.

Recommendation 8: Promote positive, well-informed, and supportive attitudes within generic public services, particularly frontline reception staff, raising their knowledge of sexual violence and their awareness of the importance of the recognising the needs of victims and not making assumptions based on how they present or who they are.

Recommendation 9: Offer the option of speaking to a woman or man to report an assault or to discuss needs for support, advice or services.

Recommendation 10: Facilitate access to interpreting and language support which must be provided by carefully selected and trained individuals and recognise the critical importance of confidentiality and of impartiality.

Recommendation 11: Clearly define and share information about pathways into local services and links between Police, NHS, and third sector providers of sexual violence services of provision.

6.3 PROVIDING RESPONSIVE AND HIGH QUALITY SERVICES

Individuals and organisations emphasised the importance of seeking to ensure local people have access to specialist Police and NHS staff with expert knowledge both related to sexual violence and good awareness of the complex needs of victims with specific needs related to mental health, learning disabilities. In addition, they stressed the importance of responsive services planned around the individual and their needs, not on assumptions related to culture, lifestyle, or identity. Priority areas relating to the quality of services are summarised below:

Recommendation 12: Seek to ensure the Police and NHS response is appropriate and sensitive to individuals' needs, right from the very first point of contact with the service, and is based on clearly defined and publicised quality standards.

Recommendation 13: Protect the privacy and dignity of victims or service users, and ensure there is an explicit focus on offering clear choices and securing informed consent at every stage of contact with services.

Recommendation 14: Improve the communication with victims or service users about progress in cases reported to the police and provide better explanations and support when cases are not taken to court or when there is no conviction.

Recommendation 15: Invest in training sexual violence staff in the diverse needs of victims and in raising other organisations' awareness of sexual violence and how to support people to safely disclose experience and access appropriate support and service.

Recommendation 16: Seek to improve access to longer-term counselling, support and help for people with historic abuse and ongoing problems (such as lack of confidence or self-esteem) or concerns (such as a need for help with anger management, or worries about their own behaviour towards partner/s).

6.4 ADDITIONAL RECOMMENDATIONS FOR THE NEW SARC SERVICES

The researchers welcome the commissioners' commitment to using the findings of this research to influence planning, publicising, and providing services at the new Blue Sky Centre. The above recommendations all have relevance to this commitment, and in addition the research identified specific suggestions for the SARC, as summarised below.

Recommendation 17: In raising public awareness of the Blue Sky Centre, we recommend the following suggestions are considered:

- seek to counter negative media coverage and challenge myths and fears about services
- make concerted efforts to convey that the SARC is a welcoming service for EMG, LGBT, disabled, learning disabilities, mental health, men, people who sell sex
- provide information in different languages and formats, recognising some people may need to access information online, others in written form, others by word of mouth
- invest in outreach through established community groups and trusted representatives
- provide clear information about entitlement to accessing help from the Police and/or NHS without disclosing personal details
- promote positive messages about the services, choices available, and benefits of getting help following rape or sexual assault.

Recommendation 18: In promoting access to the Blue Sky Centre, the following practical considerations should be addressed:

- the need to be very clear on the remit of the SARC, what services are available and who it is for
- the choices and process for people accessing the services, and what happens afterwards
- develop and maintain good links to referral agencies including both specialist organisations and generic services to which people may initially present
- clear statements in all publicity regarding confidentiality and privacy
- minimal waiting times, efficient appointments systems, and opening hours to suit clients
- accessible transport links
- safe discreet access to the SARC without it being obvious to onlookers who is attending
- a safe, supportive environment within the SARC and pleasant surroundings.

Recommendation 19: In ensuring services at the Blue Sky Centre are responsive to diverse needs and consistently high quality, priorities should include:

- ensuring all staff are suitably trained and supervised to deal with the range of clients who may need to access SARC including people with mental health issues or learning disabilities
- making good use of local experience and expertise in training staff, both in sexual violence issues and diversity considerations, and emphasising the expectation that staff are sensitive, empathetic, and able to provide tailored responses to individual needs
- protecting the safety of service users and ensuring they are seen by SARC staff in private, without family members or 'escorts' in the room
- offering a choice of gender of staff to talk to about the rape or assault and to provide advice and psychosocial support

- providing access to staff with variety of language skills, or translators who have been very carefully selected and trained, recognising the perceived risk of translators from EMG communities disclosing information about clients, or not translating appropriately
- minimising the number of times an account of the rape or sexual assault has to be given by the victim to different staff
- protecting the dignity of clients throughout the examination process and afterwards, including provision of clothes for those who are not able to have their own brought in
- considering and making arrangements for leaving the SARC following initial appointments, particularly at night, ensuring people have someone trusted and/or somewhere safe to go to
- establishing and promoting good links between the SARC and services that may refer to or take referrals from the centre and a wider network of local organisations working with diverse communities and vulnerable groups.

6.5 CONCLUSIONS

Following presentation of our findings to the Coventry and Warwickshire Sexual Assault Strategic Board, this report will be shared with all contributors and disseminated widely. The views of local individuals and organisations will be used to shape decisions about local service development and delivery and to influence ongoing plans to raise awareness of sexual assault support and services. In addition, commissioners have reiterated their commitment to continuing to engage local groups and tapping into their experience, expertise, and reach into diverse groups as plans for new SARC services progress.

The researchers once again offer our sincere thanks to everyone involved in this project. Individuals showed courage in sharing their views of a deeply personal and traumatic issue, and organisations showed generosity in sharing their experience with us. Commissioners and research participants alike demonstrated a strong commitment to improving local protection and support for individuals who have been assaulted. This bodes well for continued collaboration to deliver better health and forensic outcomes locally, and should have a positive and lasting impact on provision of the Blue Sky centre.

Appendix 1: Invitation to Engage, Online Survey and Interview guides

Invitation to Engage

94 White Lion Street, London N1 9PF T 020 7407 4010 www.mbarc.co.uk

Do you want to help make public services better for your community?
Do you know anyone who has been raped or sexually assaulted?
Do you know about local services for people who have been raped or sexually assaulted?
Do you have ideas about how police and health services can be easier for local people to contact and use?
Do you have suggestions about ways to improve the support and protection provided to people who have experienced sexual violence?

If the answer to any of these questions is "YES", we want to hear from you!
We are an experienced research organisation and have been invited in to Warwickshire and Coventry to find out what individuals and community groups want from the new Sexual Assault Referral Centre being developed by the NHS, Police, and Local Councils. These public services are concerned that not enough people are getting the protection, services, and support they need if they have been raped or assaulted. They want to hear from local people about what prevents or discourages you from going to the police or NHS and what might help to make these services more accessible and more suitable for your community.

What's in it for me?
Your involvement will help services to become better at understanding and meeting the needs of local residents. They are keen to hear from a diverse range of individuals and community groups and gather the views of women, men, LGBT communities, people from minority ethnic groups, faith communities, people living with mental illness, drug and alcohol problems or learning disabilities, and disabled people. The more we hear from diverse communities, the more suited to their specific needs future services for people who are raped or sexually assaulted will be.

We are able to offer a small cash incentive for individuals or community groups able to participate in this research. In addition, we will share the findings of our research with you and acknowledge your organisation's contribution (with your consent). The partnership developing the new Sexual Assault Referral Centre is committed to continuing to involve local people as service develop, so you will also have the opportunity to sign up to being consulted on future plans as they develop.

How can you get involved?

We have a small team of researchers (men and women) working in Warwickshire and Coventry from April to mid-July 2012 and they will be happy to hear from you and will make it as easy as possible for you to share your views and experience with us. Any information you share with us will be gathered, stored, and reported in ways that protect your privacy. You can talk to us (02074074010) or e-mail us (alasdair.stuart@mbarc.co.uk or jennifer.reiter@mbarc.co.uk) to find out more about the project.

If you are able to get involved, you will be able to provide information by telephone, by completing a confidential survey, or by meeting one of the researchers in a setting that is safe and comfortable. We would welcome opportunities to visit local community settings if there are several staff, volunteers, or service users who might want to talk informally in a group setting rather than responding individually.

DID YOU KNOW.....?

Rape is sex without consent and can happen to anyone, of any age, from any community, in any setting

Sexual assault or violence can take many forms, and can also affect anyone at any time and place

More often than not, the rapist or assailant is known to their victim, and may be their partner or spouse

The Police have specially trained officers to respond to sexual violence and support victims throughout the criminal justice process

You can report rape to the Police anonymously, or on behalf of someone else

Forensic evidence can still be gathered up to 7 days after a rape, although the sooner it is retrieved the better

If you don't want to report to the Police, you can still be supported by specialist services including Independent Sexual Violence Advocates

The NHS can provide a range of sexual health services following a rape or sexual assault, including emergency contraception, HIV prevention, and treatment for infections or injuries

A number of local services provide counselling and emotional support for victims

People who have been raped will have choices about what happens to them every step of the way once they have made initial contact with the Police, NHS, or third sector organisations

When they receive information about a reported rape, Warwickshire Police arrest and question the accused in almost all cases.

Nationally 58% of people charged with rape are convicted.

Online Survey

Purpose of this survey

We are an experienced research organisation and have been invited in to Warwickshire and Coventry to find out what individuals and community groups want from the new Sexual Assault Referral Centre being developed by the NHS, Police, and Local Councils. These local services are concerned that not enough people are getting the protection, services, and support they need if they have been raped or assaulted. They want to hear from local people about what prevents or discourages you from going to the police or NHS and what might help to make these services more accessible and more suitable for your community.

Your involvement will help local services to become better at understanding and meeting the needs of local residents. They are keen to hear from a diverse range of individuals and community groups and gather the views of women, men, LGBT communities, people from minority ethnic groups, faith communities, people living with mental illness, drug and alcohol problems or learning disabilities, and disabled people. The more we hear from diverse communities, the more suited to their specific needs future services for people who are raped or sexually assaulted will be.

Type of respondent

1. Are you responding to this survey as:

- ◯ An individual
- ◯ On behalf of an organisation

If you are responding as an individual, please go to section one.
If you are responding on behalf of an organisation, please go to section two.

Section One: Responses from Individuals (Part 1)

2. Do you have any experience of using local services such as the police, the NHS or local authority/council services?

- ◯ Yes
- ◯ No

3. If yes, how would you rate this experience?

	Very positive	Positive	Average	Negative	Very Negative
Local police	◯	◯	◯	◯	◯
Local NHS services	◯	◯	◯	◯	◯
Local Authority/Council services	◯	◯	◯	◯	◯

4. Do you think there are any barriers to using these services?

- ◯ Yes (please tell us what these are below)
- ◯ No

If yes, what are these barriers?

5. Do you have any suggestions to improve local services to make them more approachable and responsive to you or your community?

Responses from Individuals (Part 2)

6. Do you know anyone who has been raped or sexually assualted?

- ◯ Yes
- ◯ No

7. Have you heard about local services for people who have been raped or sexually assaulted?

- ◯ Yes
- ◯ No

8. Do you think there are any barriers to reporting rape or sexual violence to the police?

- ◯ Yes (if yes, please tell us what these are below)
- ◯ No

If yes, what are these barriers?

9. Do you think there are any barriers to accessing health services and other support if you have experienced rape or sexual assault?

- ◯ Yes (if yes, please tell us what these are below)
- ◯ No

If yes, what are these barriers?

10. What do you think could prevent people from going to the police or NHS if they have been raped or sexually assaulted?

11. What do you think could be done to encourage more people to report rape or sexual assault?

12. Do you have any suggestions about ways to improve the support and protection provided to people who have experienced rape or sexual assualt?

Section Two: Responses from Organisations

13. If you are responding on behalf of an organisation, we would be interested to know which organisation, and how your work relates to sexual assualt and rape.

If you would rather we did not identify your organisation by name in the research we will keep this information confidential (please state if you would like us to do so).

14. Do you think there are any barriers to reporting rape or sexual violence to the police?

- ◯ Yes (if yes, please tell us what these are below)
- ◯ No

If yes, what are these barriers?

15. Do you think there are any barriers to accessing health services and other support if you have experienced rape or sexual assault?

- ◯ Yes (if yes, please tell us what these are below)
- ◯ No

If yes, what are these barriers?

16. What do you think may prevent people that you work with/from your community going to the police or NHS if they have been raped or sexually assaulted?

17. What do you think could be done to encourage more people to report rape or sexual assault?

18. Do you have any suggestions about ways to improve the support and protection provided to people who have experienced sexual violence?

Please move on to section three of the survey.

Section Three - Who is completing the survey

We are interested in gathering responses to this survey from a wide range of individuals and organisations. To help us understand who has responded to the survey, it would be helpful if you could tell us some information about yourself.

Nothing that you tell us will be used to identify you personally.

19. Please tell us your gender:

- ☐ Male
- ☐ Female
- ☐ Trans/Intersex

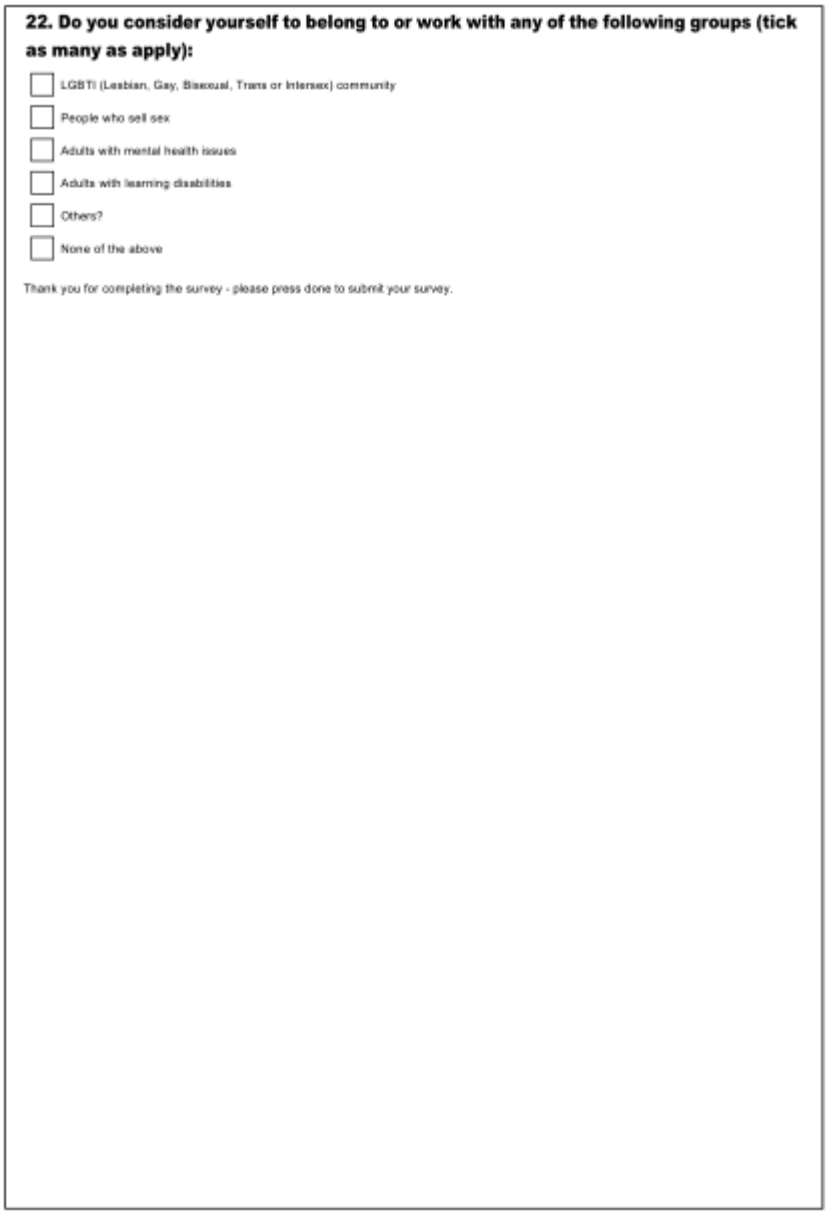
20. What age are you?

- ◯ Under 18
- ◯ 18-25
- ◯ 26-35
- ◯ 36-50
- ◯ 51-65
- ◯ Over 65

21. How would you describe your ethnicity?

- ◯ White - British
- ◯ White - Irish
- ◯ Any other White background (please specify below)
- ◯ Mixed - White and Black Caribbean
- ◯ Mixed - White and Black African
- ◯ Mixed - White and Asian
- ◯ Any other mixed background (please specify below)
- ◯ Asian or Asian British - Indian
- ◯ Asian or Asian British - Pakistani
- ◯ Asian or Asian British - Bangladeshi
- ◯ Any other Asian background (please specify below)
- ◯ Black or Black British - Caribbean
- ◯ Black or Black British - African
- ◯ Any other Black background (please specify below)
- ◯ Chinese
- ◯ Other Ethnic Group (please specify below)
- ◯ Not Stated

Where you have stated other, please specify:



22. Do you consider yourself to belong to or work with any of the following groups (tick as many as apply):

- ☐ LGBTI (Lesbian, Gay, Bisexual, Trans or Intersex) community
- ☐ People who sell sex
- ☐ Adults with mental health issues
- ☐ Adults with learning disabilities
- ☐ Others?
- ☐ None of the above

Thank you for completing the survey - please press done to submit your survey.

Coventry & Warwickshire SARC Research - Interview Guide for Individuals

Introduction & purpose of the research

- Confidentiality
- Right to end the interview

Experiences of accessing local health/police/other local services in general

- What are your experiences of using or accessing local health/police services?
- Do you think there are any barriers to accessing these services (actual experience or perceived barriers)
- Do you have any ideas about how to improve local police and/or health services?

Do you have experience or knowledge of local services for people who have been raped or sexually assaulted? Yes/No

If yes:

- Can you tell us a bit about this experience?

- Did you report this to anyone (police, NHS, other services)?
- If not, can you tell us why?

If it was reported:
- What were the services you used, and how did you find out about them?
- Was there anything that made accessing the services difficult?
- What did you think of the services you used (health/police/other services)?
- Was there anything about the services which you did not like?
- How did you find the staff that you encountered?
- What (if any) support/follow-up did you get after you used these services?

If no:
- Would you know where to go for help if you or someone you know experienced rape or sexual assault?
- What do you think might stop you from reporting a rape or sexual assault?

Questions to ask all interviewees
- Do you think there are any barriers to reporting rape or sexual violence to the police?
- Do you think there are any barriers to accessing health services and other support if you have experienced rape or sexual assault?
- What do you think could prevent people from going to the police or NHS if they have been raped or sexually assaulted?
- What do you think could be done to encourage more people to report rape or sexual assault?
- Do you have any suggestions about ways to improve the support and protection provided to people who have experienced sexual violence?
- What might help to make services more accessible and suitable for your community?

Understanding of definitions of rape and sexual assault
- What do you think constitutes consensual sex?
- Are you clear about what can be classed as rape and/or sexual assault?
- Do you think there is enough information about what constitutes consent, and at what point something can be classed as rape or sexual assault?

Close Interview
- Gather info on age, ethnicity, gender
- Note whether in any of target groups
- Onward referral for support if wanted/necessary

Coventry & Warwickshire SARC Research - Interview Guide (Organisations)

Introduction & purpose of the research
- Confidentiality
- Right to end the interview

Gather information on Organisation
- Name of organisation
- What they do/who they work with
- Where they work

Questions to ask all interviewees
- Do you think there are any barriers to reporting rape or sexual violence to the police?

- Do you think there are any barriers to accessing health services and other support if you have experienced rape or sexual assault?
- Are there any barriers particular to the clients that you/your organisation works with?
- What do you think could prevent people from going to the police or NHS if they have been raped or sexually assaulted?
- What do you think could be done to encourage more people to report rape or sexual assault?
- Do you have any suggestions about ways to improve the support and protection provided to people who have experienced sexual violence in general?
- Do you have any suggestions about ways to improve the support and protection provided to people who have experienced sexual violence that you work with?
- What might help to make services for people who have been raped or sexually assaulted more accessible and suitable for your community?

Questions to ask all interviewees

- Any specific experiences/knowledge of people they have worked with who have suffered sexual violence?

Awareness of Sexual Assault Services

- Are you aware of services for victims of sexual assault and rape?
- If so what, and where did you hear about them?
- What do you think would be the best ways to inform community groups, local organisations and local people about the new SARC?

Understanding of definitions of rape and sexual assault (dependant on type of organisation)

- What do you think constitutes consensual sex?
- Are you clear about what can be classed as rape and/or sexual assault?
- Do you think there is enough information about what constitutes consent, and at what point something can be classed as rape or sexual assault?

APPENDIX 2: THE MBARC TEAM

Details of the research team:

Alasdair Stuart is a researcher at MBARC. He is leading our London-wide needs assessment into the sexual health needs of LGBT students and has been contributing to a review of London's Sexual Assault Referral Centres. He has recently completed the evaluation of our "Going All The Way" specification for sexual health services piloted in three London Further Education Colleges. In addition, he co-ordinated MBARC's support to the international consortium developing the human rights charter from LGBT asylum seekers.

Prior to joining MBARC Alasdair worked as a research consultant for one of Scotland's leading social research consultancies. He has undertaken extensive health and social care related research, including a workforce mapping and training needs assessments of the physical activity workforce, and supporting the development of a drug and alcohol workforce development strategy, both for NHS Health Scotland. He has also conducted a scoping exercise for a programme to upskill the community learning and development workforce on behalf of the Scottish Government.

Helen Davies is the MBARC Associate Consultant leading on the London Sexual Violence Needs Assessment and SARC review, and has recently delivered consultancy assignments on mental health issues and learning disabilities services.

Prior to becoming a consultant in 2011, she spent 10 years as Health Policy Manager for the Greater London Authority, leading development of the London Health Inequalities Strategy and delivery of the Mayor's health policy and partnership programmes. She spent the previous 15 years working in the NHS, Social Services, and Department of Health in health and social care roles from practitioner, manager, and service provider to commissioner and inspector of services for people with complex needs including those related to HIV, disability, and substance misuse. She holds non-Executive roles on mental health, patient involvement, and leadership development.

Jennifer Reiter is the Sexual Health Projects Coordinator at MBARC. Her role is to co-ordinate the delivery of the 2012 Olympics Sexual Health and Further Education Sexual Health Programmes on behalf of the London Sexual Health Programme Board.

Jennifer has worked and volunteered in the field of sexual and reproductive health care for ten years. Prior to her role at MBARC she was a Trainer and Project Manager at Education for Choice, a charity dedicated to providing abortion and pregnancy decision-making education for young people and training for professionals. In the U.S., she was a reproductive rights advocate for chapters of Planned Parenthood in Wisconsin and Illinois. She also coordinated projects on implementing rapid HIV testing in hospital emergency departments and routine HIV testing in antenatal care.

Steven John is an MBARC Associate and independent consultant and interim manager. He has extensive experience as a practitioner, service manager, and commissioner within both NHS and local authority settings and has worked at the interface between the statutory, independent and third sectors. He has been responsible for developing and managing services to adults with mental illness, learning disabilities, HIV, or substance misuse issues. In addition, he has led development of commissioning strategies for these client groups in line with the personalisation, adult safeguarding, re-ablement and recovery agendas.

The research was supported by the following:

Michael Bell is the Practice Director at MBARC, an organisation he established in 1993. Since that time he has led more than 400 research and consultancy assignments. In addition to his role at MBARC he is Vice Chair of NHS London, the strategic health authority for the capital. He is also Chairman of the London Mental Health and Employment Partnership, Vice Chair of the London Health Observatory and served as a Commissioner on the Mayor's London Health Commission from 2008 until 2011. Michael is the first non-clinician to be appointed to the Board of BASHH the British Association of Sexual Health & HIV.

Stephanie Reardon is an Associate Consultant with specialist knowledge in sexual violence policy development and service delivery. Until March 2011, she was the Delivery Manager for the Department of Health's National Support Team for Response to Sexual Violence and prior to this, she was the National Programme Manager for the DH Violence and Abuse Prevention Programme. In addition she was seconded to the Serious Organised Crime Agency (SOCA) Child Exploitation and Online Protection (CEOP) Centre in 2007/8. Since leaving the DH she has continued to work in the field of sexual violence, establishing a specialist training organisation, completing Sexual Violence Needs Assessments, and working with a range of NHS and Police partners on improving sexual violence services.