



Sexual Violence Needs Assessment for the West Midlands Police Area

Summary Report

November 2011

Sexual Violence Needs Assessment for the West Midlands Police Area

Birmingham East and North Primary Care Trust

Submitted by GHK Consulting Ltd in association with Dr Angela Morgan

Dr Nahid Ahmad
30 St Paul's Square
Birmingham
B3 1QZ
0121 233 8900
nahid.ahmad@ghkint.com
www.ghkint.com

Document control

Document Title	Sexual Violence Needs Assessment for the West Midlands Police Area: Summary Report
Prepared by	Dr Nahid Ahmad, Aidan Moss, Deirdre O'Brien, Rakhee Patel, Oliver Jackson, Fraser Battye and Dr Angela Morgan
Checked by	Fraser Battye
Date	22 nd November 2011

Acknowledgements

The needs assessment was undertaken by GHK, but – given the amount of information gathered in the comparatively short period of time available – it is more accurately described as a collaborative effort. A very wide range of stakeholders and organisations gave their time (and data).

Within this group, the study team would like to extend particular thanks to:

- The survivors of sexual violence who shared their experiences and reflections on services;
- The agencies (Birmingham RSVP, CRASAC, Crisis Point, and Sandwell Women's Aid) that supported these survivors and facilitated GHK's access to them;
- Members of the project steering group who provided particular inputs and general guidance to the study; and,
- The SARCs that participated in the consultation and supplied information on their services: the Haven Paddington, St. Mary's, The Bridge, Hope House, and Treetops.

GHK would also like to extend thanks to the expert panel which acted as a steering group for this needs assessment: Jim McManus; David Walker; Tracey Thorne; Paul Sanderson; Lisa Thompson; Rachel Jones and David Reily.

Any errors in the interpretation or presentation of information provided remain GHK's.

One page summary

This is a one page summary of a sexual violence needs assessment for the West Midlands Police Force Area. The assessment was undertaken by GHK and Dr Angela Morgan.

Key findings are that existing services, centred around the Sexual Assault Referral Centre (SARC), have gaps in relation to:

- Access: variation by local authority area; lack of self-referral; lack of knowledge of the SARC in other services; meeting small proportion of estimated need;
- Quality: not meeting nationally specified minimum standards for SARC; highly variable quality of services for children and young people; and,
- Coordination: no formal care pathways for adults or children and young people; resulting poor coordination of care for victims.

Recommendations for the *next year* are to:

- Formally establish an agreed set of pathways – for both adults and children and young people. All agencies involved should then support the coordination of services against these pathways. Awareness raising across services is critical.
- Introduce 24 hour crisis support workers at the SARC. Pooled budgets / joint commissioning arrangements are appropriate here.
- Combine Genito-Urinary Medicine and other health services with the current Forensic Medical Examination (FME) service.
- Strengthen clinical governance by appointing a clinical director.
- Work to develop self-referrals (once improved service has become established).
- Review current children and young people's services with a view to aggregating FME services into fewer, more specialist, NHS Trusts.
- Undertake a feasibility study to examine the possibilities of new facilities (most likely in Birmingham). Children / young people's services should be considered.

And in the *next two to three years*:

- Fully develop joint commissioning / governance arrangements; commission services, such as Independent Sexual Violence Advisors, where there are gaps.
- Commission evidence-based programmes to promote prevention, e.g. in schools.
- Move into new facilities.
- Use SARC as a hub for intelligence, maintaining data and information on sexual violence to inform services and commissioning plans.

The in the *next three to five years*:

- Become a centre of excellence, providing the highest standards of care to victims.

The requirements of policy and practicality demand a partnership-based approach: no single organisation can deliver these improvements. Partners must therefore understand their remit and priorities in relation to sexual violence and invest accordingly.

Introduction

Main message from this section:

In 2009, a National Support Team from central government reviewed the Sexual Assault Referral Centre (SARC) in the West Midlands Police Force Area. The review recommended undertaking a needs assessment. This was commissioned in June 2011 from GHK. A summary of results is contained in this document.

The impact of sexual violence can be profound and far-reaching. For individual victims, there are immediate risks to physical and sexual health. Over the medium- and longer-term, the damage is often to mental health: many victims subsequently experience depression, substance abuse, anxiety and even suicide. Negative effects thereby ripple out through victims' families, friends and communities. At a societal level, there is a need to address the needs of victims and the crimes of perpetrators. Moreover, there is a need to do so cost-effectively – to balance and coordinate investments to best meet these needs.

Historically, the victims of sexual violence have not been well served. Yet, through a series of recent reviews and policy developments, these needs have been given greater emphasis. Accepting some uncertainties relating to the current reform of the NHS, there is a clear policy direction in this area. One key theme here is the need for strategic and operational partnerships between agencies – notably the NHS, local authorities, the Police and specialist voluntary sector organisations. Such an approach is critical to the ambition of providing safe and effective services that meet the full range of victims' needs.

Services have developed in response to this policy drive. One of the main innovations in this respect has been the development of Sexual Assault Referral Centres (SARCs). Exact models of service vary by local area, but all are defined and guided by a set of minimum standards (Department of Health, Home Office and the Association of Chief Police Officers, 2009) and all aim to provide a one-stop service immediately following an offence. The policy intention is to have a SARC in each Police Force Area by this year.

National policy is clear; local implementation is highly variable. Practice ranges from areas such as Manchester - where SARC services have been prioritised and invested in accordingly - to areas with no SARC.

In 2009, SARC services in the West Midlands Police Force Area (hereafter: 'West Midlands') were reviewed. These services are provided at two centres (the 'Rowan Centres'): one in Walsall and one in Castle Vale (Birmingham). The review was undertaken by the Department of Health and Home Office 'National Support Team' (NST).

The NST report highlighted several strengths of the service, but dwelt largely upon the various areas for improvement. Fundamentally, the NST concluded that services in the West Midlands did not meet the national minimum standards. To support partners in addressing these (and other) gaps, the NST made several recommendations – one of which was to undertake a needs assessment.

In June 2011, GHK, in partnership with Dr Angela Morgan, was commissioned by NHS Birmingham East and North Primary Care Trust (PCT) - on behalf of three NHS clusters,

seven local authorities, the Police, Crown Prosecution Service and voluntary sector in the West Midlands - to undertake this assessment.

Following national guidance on the development of SARCs, the study covers the West Midlands Police Force Area (PFA). This is distinct from the West Midlands region (as covered by NHS West Midlands); work is underway in areas within the region, but not the PFA, such as Warwickshire, to develop services for victims of sexual violence.

The specified outcomes, given in the terms of reference for the assessment, were to:

- *“Identify a baseline data set from within the West Midlands (PFA) to include the following; identify incidence of sexual violence (rape, sexual abuse and sexual assault), at risk groups, basic SARC data and evidence of outcomes from both health & criminal justice.*
- *Identify current resources available for victims of rape and sexual assault in the West Midlands (PFA) making reference to national standards and good practice.*
- *Identify current pathways for victims of rape & sexual assault within the West Midlands (PFA).*
- *Ensure that the views and experiences of victims and service users are included in this needs assessment and that there is appropriate mechanism for involvement in shaping the development of the SARCs in the West Midlands (PFA).*
- *Identify gaps and unmet needs in provision and pathways for victims of rape and sexual violence against core national standards and good practice in other SARC services.*
- *Identify the priorities for commissioners to develop the SARC service within the West Midlands (PFA) taking account of national standards and current policy.”*

In addition to these outcomes, at the inception stage of the study the steering group emphasised that the needs assessment should:

- Take a ‘whole system’ approach and look broadly at services for victims of rape, serious sexual assault and sexual abuse (i.e. not focus on the SARC in isolation); and
- Go beyond a ‘traditional’ needs assessment to look beyond a detailed definition of current problems and towards options for possible service responses.

Research to address these outcomes included: interviews with survivors of sexual violence; a review of available data; a general ‘call for information’ issued to stakeholder organisations; a review of national policy; a mapping of current services; brief reviews of relevant literature; examination of other SARC services; and interviews / a focus group with key stakeholders. This was undertaken in July and early August.

A note on data used and its limitations

There is no single source of data that can address the requirements of a sexual violence needs assessment. Following national guidance (Department of Health, 2011), this study drew upon a wide range of sources – both quantitative and qualitative. This is the first time many of these sources have been brought together.

In using the quantitative data, one important consideration was to keep a distinction between the problem (or need) and take up of services. This was partly to enable

consideration of the gap between the two, and partly to address the problem of under-reporting of these crimes (and associated 'under use' of services).

In quantifying the problem, the study therefore drew on data from the British Crime Survey's (BCS) 'interpersonal violence module'. This is because the BCS provides data over time, for a range of offences, at sufficient scale to allow sub-group analysis, and reduces problems associated with reporting / recording of these crimes. Rates derived from the BCS were combined with data on the demographics of the local populations in the West Midlands. Where this was not possible – notably in the case of children / young people and specific vulnerable groups – rates were taken from previous research and again applied, as far as possible, to the local context. Lastly, Police data were also used to provide further evidence.

In quantifying the take up of services, the study drew upon data returned through the 'call for information' and that obtained through stakeholder consultation. The analysis concentrated upon the nature and scale of access to different services, drawing contrasts with the estimated scale of the problem to highlight possible gaps in provision and access.

Finally, there are gaps in the data – notably in relation to the scale of the problem and service access for children and young people, and also where 'finer' analysis is required for specific target groups. This study is the first time that the data used have been brought together; they can be updated and improved as services are developed, using the SARC as a hub for intelligence on an ongoing basis.

The full results of the research are contained in a full and detailed 'Technical Report'. Readers wanting the full evidence base for points made here are kindly referred to that document. This 'Summary Report' has been produced to support the dissemination of the main findings. It is presented in five sections:

1. Presents data on the extent of the problem of sexual violence in the West Midlands, for adults, children and young people, and specific vulnerable groups.
2. Presents data on access to services.
3. Comprises a summary of stakeholders' views of services and the current pathways for adults and children / young people.
4. Contains a description of victims' needs and their views on the services they received.
5. Draws on all the evidence gathered to present a set of options for the development of services in the West Midlands.

These sections are supported by three Annexes: the first presents an analysis of existing services in the West Midlands against the national minimum standards for SARC; the second presents a limited bibliography of sources referred to directly in this summary; and the third outlines the method used to gather evidence for the needs assessment.

1) What is the nature and scale of the problem?

Main message from this section:

Sexual violence affects some groups within the population far more than others. The different demographic profile of each local authority within the West Midlands means that the problem is far more prevalent in some areas than others. Overall, the scale of the problem is declining slightly over time, but rates of reporting are increasing; this has implications for planning services.

As noted above, the harm caused by sexual violence can be severe. This harm is also very unevenly distributed across the population. **For adults**, BCS data shows that:

- *By far the majority of victims are female.* Close to 20% of women surveyed by the BCS claimed to have been a victim of sexual assault during their adult lives, compared to only 2% of men;
- *The young are at greater risk.* This is especially true for females: those aged 16 to 19 were twice as likely to be victims of sexual violence as those aged 20-24 - and 11 times more likely to be victims than those aged 55-59;
- *Poorer groups are at greater risk.* Unemployed males and females were 2.8 and 2.6 times more likely to be victims than employed males or females respectively;
- Having a *long standing disability* also appeared to be a risk factor across both sexes, although this was only statically significant for males;
- *Single and separated people were at a higher risk* of sexual violence;
- *Women who attend bars or nightclubs more than once a week* were 2.3 and 4.5 times respectively more likely to be victims than women who never went; and,
- *Ethnicity did not appear to be a risk factor.*

The BCS also shows the largely 'domestic' nature of much of this crime. Over half of those who reported being a victim of rape since the age of 16 were raped by a partner (45%) or former partner (9%). Only 17% were raped by strangers and 4% were 'date raped'. Yet data from West Midlands Police suggests that rapes by strangers are more likely to be reported: over half of the (577) suspected rapes investigated in 2010 involved total or near-total strangers.

Data from the BCS were combined with population data for local authority areas within the West Midlands. Where possible, adjustments were made to allow for the different demography of these areas - and therefore the likely prevalence of sexual violence given the factors highlighted above. This exercise showed that:

- Approximately 193,000 adults living in the West Midlands have been a victim of some form of sexual violence at some point in their adult lives. Just under half are believed to live in Birmingham and around 20% in Coventry; and,
- In the last year an estimated 24,000 adults in the West Midlands were victims of sexual violence (including attempts) – around 3,200 of which were serious sexual assaults (excluding attempts) and 2,700 were rapes. This is shown below:

Table 1.1 An estimated 3,200 people were victims of serious sexual assault in the West Midlands in the last year

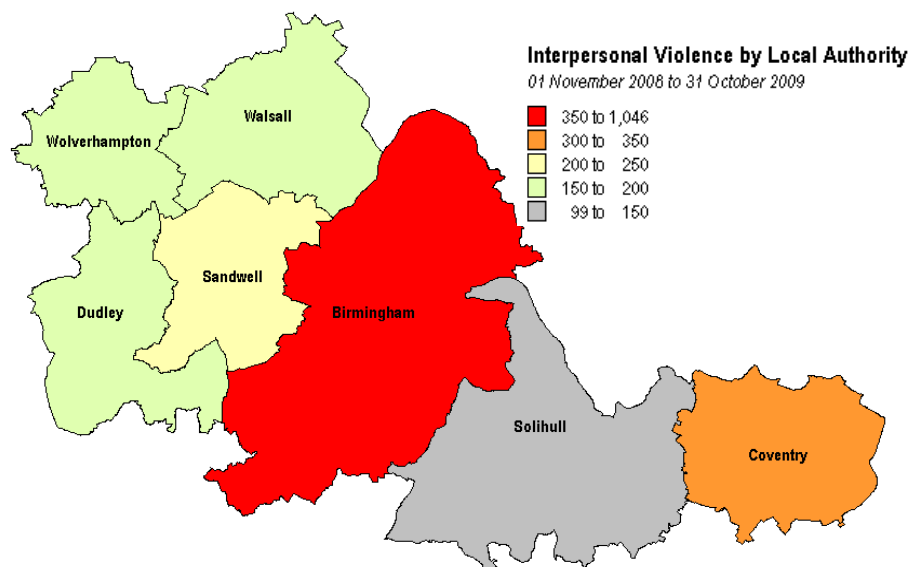
	Serious sexual assault			Rape		
	Total	Male	Female	Total	Male	Female
West Midlands	3,200	200	3,000	2,700	120	2,600
Birmingham	1,500	90	1,400	1,200	60	1,200
Coventry	450	30	420	400	20	360
Dudley	260	20	240	200	10	200
Sandwell	360	20	330	300	15	300
Solihull	170	10	150	140	6	130
Walsall	240	15	220	200	9	190
Wolverhampton	290	20	270	250	11	230

Source: BCS 2009/10, ONS 2010 mid-point estimates, GHK calculations

As Table 1.1 above shows, the problem is concentrated in specific geographical areas. This is further illustrated in Figure 1.2 and Figure 1.3 below. They show that Birmingham has the highest level of interpersonal violence, followed by Coventry; and that within Birmingham incidents are concentrated within specific parts of the City (a similar finding was reported in analysis for Coventry City Council in 2011, which found that a disproportional amount of offences took place in the city centre).

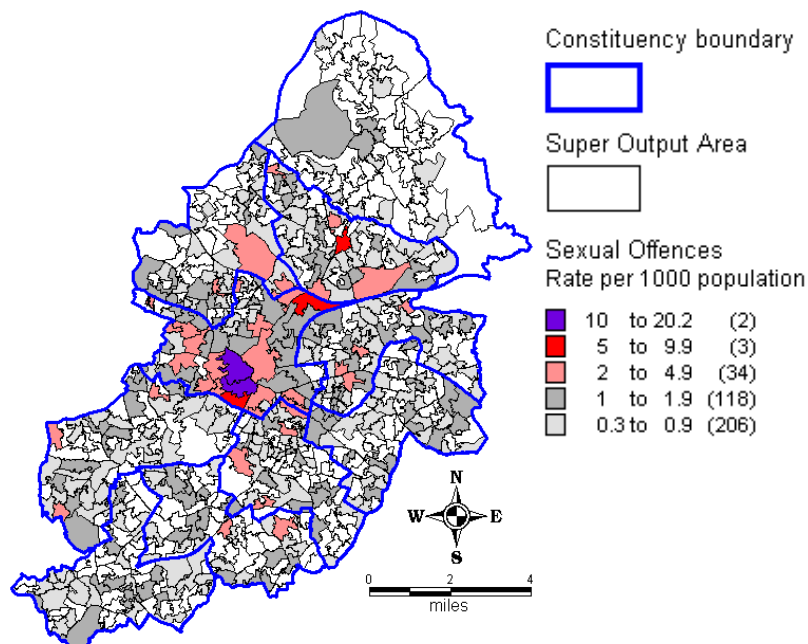
While offences were clearly distributed geographically, data from West Midlands Police suggest little clear pattern by way of temporal distribution – either by month, day or time of day. One exception here was a trend for later (in the night) reporting at weekends.

Figure 1.2 In 2009, interpersonal violence was highest in Birmingham and Coventry



Source: Dudley Community Safety Partnership

Figure 1.3 Birmingham's reported sexual offences were concentrated in specific parts of the City



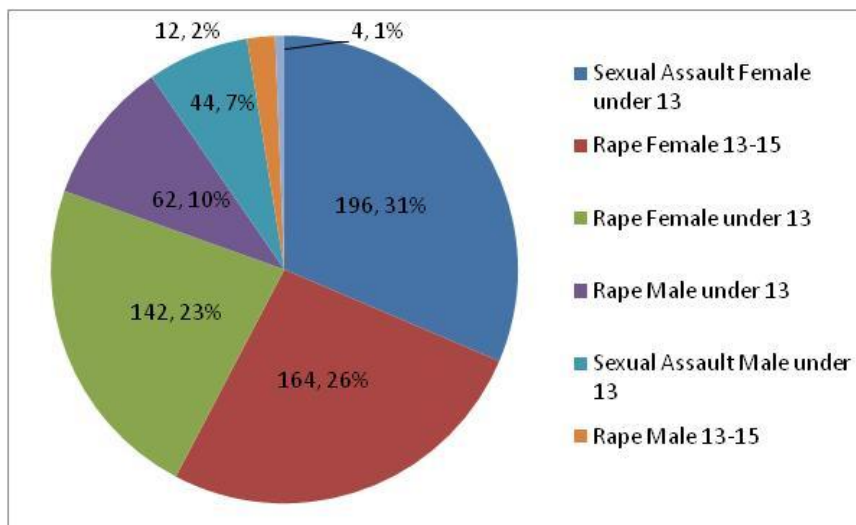
Source: Safer Birmingham, 2011

Lastly in relation to adults, trends in the scale of these crimes and their reporting have implications for the development of services in the West Midlands. The evidence gathered suggests that there is expected to be a steady decline in the overall number of incidents, but that reporting of these crimes will either remain stable or increase slightly. Quantifying the extent to which **children and young people** are victims of sexual violence is challenging for definitional and methodological reasons. Moreover, as with adults, the nature of the problem tends towards under-reporting: the majority of sexual assaults on children were committed by other children and most victims knew the offender (NSPCC, 2011).

It is possible to apply rates from national research to the local populations of the West Midlands, although the data are not sufficient to allow for different demographic characteristics. The results of this exercise suggest that an estimated 63,000 children and young people have been victims of sexual abuse in the West Midlands; nearly half were victims of rape. As this is a cumulative figure over childhood (in this case taken as 0-16), dividing this result by 16 suggests that approximately 4,000 children and young people are abused every year in the West Midlands.

Over 620 serious sexual offences against children and young people were reported to West Midlands Police in 2010. Figure 1.4 presents a breakdown by age and offence type. The most common offence was sexual assault of a female under 13 (196 cases, 31% of the total), followed by rape of female between 13-15 (26%) and rape of a female under 13 (23%).

Figure 1.4 Sexual assault or rape of females aged under 13 accounted for over half of all reported sexual offences on children and young people in 2010



Source: West Midlands Police, 2010

Data on specific vulnerable groups are too incomplete to derive estimates for the West Midlands

Specific groups, such as people with learning disabilities or sex workers, are known to suffer high rates of victimisation; yet they are not well covered by the BCS or recorded crime statistics. Moreover, the available data do not allow estimates for the West Midlands to be constructed. Instead, illustrative findings from the literature and local data are summarised below:

- More than 90% of people with a learning disability will experience sexual abuse at some point in their lives (Valenti-Hein & Schwartz, 1995);
- Around 95% of trafficked women have been physically or sexually assaulted (Zimmerman, 2006);
- 27% of women identified as sex workers in the Safer Birmingham Partnership's 'On Street Prostitution Problem Profile' had been the victims of at least one sexual offence in the last nine years. This included 22% of the women reporting at least one rape – not all of which took place whilst they were working as prostitutes (Safer Birmingham Partnership, 2008)
- In a study of over 6,964 men and 564 female prisoners Wolff et al (2008) found that the rates of inmate-on-inmate sexual victimisation was as high as 21% amongst females and 4% amongst males.
- There is little specific evidence on the prevalence rate of sexual violence in Lesbian, Gay, Bi-sexual and Transgender (LGBT) communities. The BCS and other research suggests that the prevalence of domestic violence (related to, but not the same as sexual violence) may be comparable to that of the general population, but slightly higher amongst lesbians and bisexuals and significantly higher amongst transgendered individuals. However, reporting rates are lower across all LGBT groups.

2) To what extent do victims of sexual violence access current services?

Main message from this section:

Access to services is a key issue. A minority of victims currently access services and there is unexplained local variation in access.

The BCS shows that the majority of victims either tell no-one (28%), or tell a friend / relative / neighbour (33%). They do not access services - and just 2% access a SARC.

Changing this pattern is therefore fundamental to achieving the ambition of supporting victims and addressing the crimes of perpetrators. This section of the report examines the take up of key services currently provided – starting with the SARC itself. Data were supplied by the services concerned.

569 victims received a forensic medical examination (FME – a service delivered by Primecare under a contract with West Midlands Police) in the West Midlands in 2010/2011. Of these, 421 attended one of the Rowan Centres – just over two-thirds of which were seen at the Walsall site. The difference between these figures (569 and 421) is due to some FMEs taking place elsewhere - e.g. if the victim was prepubescent - and some poor historic record keeping at the Centres.

Combining the number from the previous section of the estimated number of serious sexual assaults on adults in the last year (3,200) with the 421 accessing the Rowan Centres, gives a figure of around 13% of potential users accessing the service. This is shown in the table below, where a comparison is made with the rates of access to the Nottinghamshire SARC. Note that the figure for estimated assaults in Nottinghamshire includes attempts and the figures for the West Midlands do not; this therefore overstates the relative performance of the West Midlands. The results suggest a gap in accessibility.

Table 1.2 There appears to be significant scope to increase access in the West Midlands

	West Midlands	Nottinghamshire
Estimated serious sexual assaults	3,200	1,960
Number accessing SARC	421	460
% accessing SARC	13%	23%

Sources: BSC 2009/10, ONS 2010 mid-point estimates, Burton et al (2010)

Nearly all victims (99%) were referred to the SARC by the Police and there were just three 'self-referrals'. Referrals to the SARC are higher at the weekend and there appears to be no seasonal fluctuation in use.

In demographic terms, over 90% of those receiving an FME were female. The ethnicity of SARC service users is not substantively different to the general population - suggesting that ethnicity is not a barrier to accessing the service. Despite being a high risk group, young people between the age of 13 and 15 represent just 7% of SARC users. Lastly, sex workers accounted for 1.6% of users; there is insufficient data to know

if this figure is proportionally high or low, but stakeholder interviews suggested that this group is particularly wary of attending the SARC.

Data from the Forensic Science Service (FSS) reveal that in the majority of cases victims report within three days of the offence taking place, and an FME is conducted within 12 hours of this report. Submission of evidence to the FSS is not always timely: between July and September in 2009, 30% of cases were submitted a month after the FME. This delay was deemed 'excessive' by the FSS.

Table 1.3 shows people referred to the SARC by local authority area; these numbers are contrasted with reported serious offences on over 13s. It suggests that take up (referrals relative to reported offences) is highest in Wolverhampton and Solihull, and lowest in Dudley, Birmingham and Coventry. Given the absolute scale of the problem in Birmingham and Coventry, the gap between potential and actual use is significant.

Table 1.3 Referrals to the SARC vary by local authority area

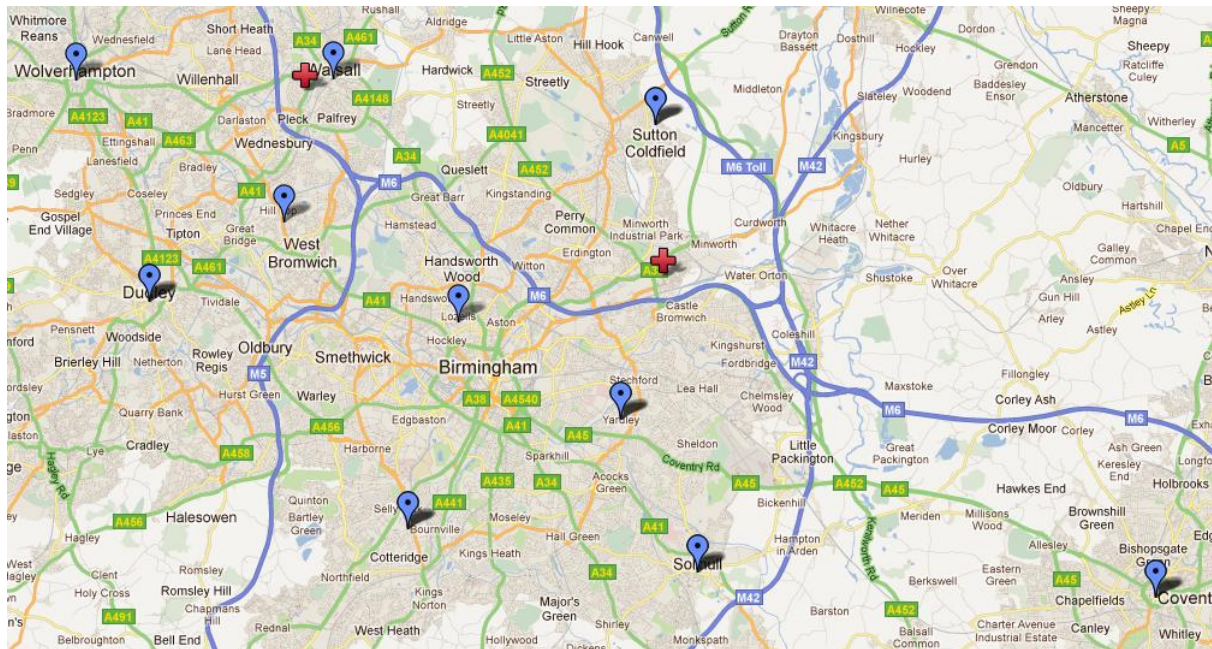
	SARC referrals	Reported serious offences	%
West Midlands	410 (421)*	1,612	26
Birmingham	173	748	23
Coventry	50	225	22
Dudley	25	111	22
Sandwell	51	186	27
Solihull	24	73	32
Walsall	35	120	29
Wolverhampton	53	149	35
Other	11	N/a	N/a

Source: West Midlands Police, 2010/11; SARC 2010

*421 victims were seen in the West Midlands SARC in 2010/11, 11 of these victims lived outside of the West Midlands PFA area

The Rowan Centres are both within 30 miles of the furthest Local Policing Unit - and are on major transport routes - removing geography as an explanation for the above variation. This is shown in Figure 1.5 below.

Figure 1.5 The Rowan Centres are both located along major transport links



Note: Each Local Policing Unit area is represented on the map below with a blue marker. The Rowan Centres are denoted by a red cross.

Pathways between the Rowan Centres and other services have improved over time, reducing what has been a substantive 'attrition rate' between key services. Between September '10 and April '11 over 90% of SARC service users were referred to Independent Sexual Violence Advisor (ISVA) services. Following improvements to the process, a similar proportion are now referred to a Genito-Urinary Medicine (GUM) clinic, although in the main referrals go to just one clinic (which is therefore unlikely to be local to victims).

Data submitted by voluntary sector organisations show that approximately 990 new clients are supported by the ISVA service per year. That this is higher than for the SARC is partly accounted for by ISVAs handling cases that are not 'forensically acute' (i.e. would be outside the period suitable for an FME). The great majority of clients are female, with people under the age of 25 accounting for over half of all users. The use of the ISVA service is therefore closer to incidence patterns than the use of the SARC is – suggesting fewer barriers to accessing this service. Voluntary sector organisations reported that they saw up to 2,000 victims of sexual abuse per year (e.g. in specialist counselling services as well as by ISVAs).

The ISVA service supports around a third of victims to begin court proceedings; less than half then see their perpetrators convicted, with the perpetrators of sexual violence in the West Midlands being convicted in approximately 15% of cases reported to the Police.

3) Do current services meet the needs of victims?

Main message from this section:

The SARC does not meet nationally specified minimum standards. Current 'pathways' through services are too informal and uncoordinated; services are also weak at various points of the pathway. There is clear scope for development – especially for children and young people.

The current set of services has evolved over time. They are characterised by various funding arrangements (some national, some local) and are provided by a range of agencies. There are no formally established pathways – either for adults or children and young people – and there are no commissioning arrangements to oversee services. Existing referral routes have therefore developed in an *ad hoc* manner, resulting in substantial variation at local level. Movement between services is not well coordinated and relies too much upon relationships between individuals in referring organisations.

The SARC is a key point in the current **pathway for adults**. As noted above, the route into the Centres is via a Police report and self-referral is not promoted. At the SARC, an FME is performed. Stakeholders raised various concerns in relation to this element of the service. In the main, these focussed upon a weakness in clinical governance, as well as specific concerns about variations in the quality of evidence gathered. Pathways out of SARC and into GUM services have developed over time (although are concentrated on one clinic), as have routes into the ISVA service.

Overall, several stakeholders (and the NST report of 2009) noted that the SARC does not meet the specified national minimum standards for a SARC (summarised at Annex 1). One of the main points made here was that the service does not focus on victims' needs in the broadest sense: it is led by the forensic requirements of the criminal justice system and pays insufficient attention to victims' broader health / support needs. Stakeholders therefore considered that GUM / other health services (e.g. to treat minor injuries) should also be provided at the SARC - as should crisis support workers, who can focus on the victim 'as a person' and coordinate care in to and out of the SARC.

The **pathways for children and young people** are more varied - partly due to the differing nature of these offences and the different services involved. In the main, these victims come through children's social care services, but stakeholders also noted the involvement of Police, schools and health services. Cases are typically not 'forensically acute' and are often therefore addressed within mainstream child protection systems, supported by counselling / therapeutic services from agencies such as Barnardo's.

Cases that do require an FME are treated in paediatric services in NHS Hospitals Trusts; several stakeholders raised substantive concerns about the variation in quality across Trusts in relation to these services and facilities. A small number of cases between the ages of 13 and 18 years are also seen at the SARC.

The **ISVA service** is crucial to supporting adults and children and young people once the 'acute' phase of the current pathway is complete. The service is delivered in local areas by different voluntary sector agencies. There are however notable gaps in this service, including: Birmingham (provision relative to size of population / need); Wolverhampton (no ISVA service); and children's ISVAs (currently only in Sandwell and Walsall).

Stakeholders were generally very positive about the ISVA service. It was cited as providing the holistic approach lacking in other parts of the pathway, and balancing criminal justice and broader support needs. It also plays a vital coordinating function – supporting users through services. Nevertheless, stakeholders noted several concerns here also; these included: the capacity of the services and the sometimes long waiting lists; the instability of funding (coming largely from national grants, rather than being locally commissioned services); and gaps in services for specific vulnerable groups (although some examples of good practice were also cited here).

4) What do victims want from services? What are their views of current services?

Main message from this section:

Victims have a clear and definable set of needs. Key elements of the services in the West Midlands were well regarded by victims, but areas for improvement were also identified.

Interviews with survivors of sexual violence undertaken for this needs assessment, combined with key themes from the literature in the area show that victims want:

<i>To have immediate access to appropriate services</i>	Victims want speedy access to 'emergency' services, as well as longer term support services such as counselling
<i>To be treated with respect, understanding and compassion</i>	Victims want to be listened to, made to feel at ease and not judged, and to not have to repeat their story each time they access a service. The manner in which services are provided is central to this
<i>To receive independent, practical, and coordinated support</i>	Victims value clear information about available services and associated processes. Having a single point of contact and an advocate who can help coordinate care is important; this is central to the value of the ISVA service
<i>To have tailored support if they have specific needs</i>	Victims want services that are sensitive to their particular needs. For example, the experiences of male victims may be substantially different from the experiences of female victims; the response of services must be shaped by these different needs
<i>To have support for family and friends</i>	Victims are aware of the effect their experience may have on those around them; there is a need to consider support for whole families and not just the individual victim

These expectations were sometimes, but not consistently, met in the cases of the small sample (five) of survivors interviewed. The main points raised here were that:

- Accepting some ways in which services could have been improved, the Police were seen as providing a helpful, respectful and well-linked service. The main factors underpinning this positive view related to the manner in which the service was provided, and the way in which subsequent referrals were made.
- Again in broad terms, the SARC service was seen as being professional, appropriate and supportive. The manner in which victims were treated – by staff and by the environment - was central to this.

- In general, victims thought that GUM services could improve. Key issues here included the need to 'repeat the story', as well as the manner of the staff involved.
- The ISVA service was highly valued. The key factors underpinning this view were the element of coordination provided, the flexibility and independence of the service, and the access provided to counselling services.
- Counselling services were generally valued and were central to some users' recovery.
- Survivors' views of other services linked to this pathway – such as GPs, mental health services and children's services – were very mixed. In general terms, these services were not seen as being sufficiently understanding or supportive.

These largely positive views should be balanced against some of the more negative evidence provided by stakeholders, especially given the very small and non-random sample interviewed.

5) What should the priorities be in developing these services?

Main message from this section:

The immediate task is to meet the nationally-specified minimum standards for a SARC – ‘do nothing’ is not a viable option. In the medium term, pathways should be developed more fully. In the longer term, the West Midlands should aim to become a ‘centre of excellence’.

There is a clear case for change: ‘Do Nothing’ is not a viable option. As they stand, services do not meet national minimum standards; by this definition there is no SARC in the West Midlands. Combined with the current institutional and funding arrangements – the Centres are largely Police funded (accepting some ‘in-kind’ capital support from two PCTs) and run – this means that neither policy goals nor victims’ needs are being met.

Drawing on the evidence gathered throughout the needs assessment, three Options for further development are presented below. Each Option presented would require further development; they are offered as a guide to development, rather than a fully-worked up plan of action or business case. Moreover, the Options are not mutually exclusive: it is possible to combine different elements.

‘Meet Minimum Standards’

This is the most immediate and practical option to improve services. It would require several key steps: establishing agreed pathways and better coordination of services; introducing 24 hour crisis support (workers); ensuring that health needs are better met at the SARC; developing more formal interagency arrangements with local specialist agencies in the voluntary sector; improving the quality of the FME offer and strengthening clinical governance; increasing self-referrals; and developing agreed pathways for children and young people. Annex 1 provides more detail on the standards and current performance, using a ‘RAG’ rating against each of the minimum standards. It is important to note that a green rating on each of these standards would still only indicate that **minimum** standards are being met.

‘A Fully Developed Pathway’

The main features of a more fully developed pathway are summarised below. In the main, these features are drawn from existing SARC services; this should not therefore be read as a hypothetical ideal, but as an approach to bringing the West Midlands into line with current practice in analogous areas.

- Changing culture is central to prevention. The SARC could expand the offer of preventive services by working partnership with youth services and schools
- Organisationally, the SARC needs robust governance, joint commissioning arrangements and skilled management; the remit should then include workforce development and acting as a hub for intelligence on sexual violence
- Ease of access is critical. The pathway should be well connected to a wide range of other local services; a wider communications strategy should be used to build partnerships and increase self referrals

-
- The SARC should provide a 'one stop shop' intended to address all the forensic, clinical and follow up care needs of clients in a holistic, non-judgmental manner
 - The SARC would benefit from new capital investment to develop a site that is fit for purpose – for all users - and future-proofed
 - Quality is vital. The NHS should lead the commissioning of a stand-alone sexual offences rota. This will allow for better clinical governance under a Clinical Director, dedicated staff and more female examiners to meet the expectations of clients
 - A specialist paediatric rota should be developed with community paediatric services. A lead paediatrician for sexual offences can develop the SARC service
 - Forensic examinations should follow best practice. Arrangements should allow clients a choice of service and options; crisis workers can support this
 - High quality follow-up sexual health care should be integrated with SARC services
 - ISVA services are essential to an integrated and well coordinated pathway. They should be linked to local voluntary sector services who are best placed to help
 - Counselling and psychological follow up care is essential to a holistic service. They should be available and offered to all clients, regardless of whether cases are acute or historic

‘A Centre of Excellence’

The final Option builds upon the previous one and provides a set of developments that would push services in the West Midlands on to become amongst the best currently available. Key developments here include:

- The SARC could develop specialist staff roles in order to better serve its local communities; there are examples from around the country which can show the way
- The SARC could become a centre for training, workforce development, research, and user involvement, building up the skills of clinical staff to meet the challenge of expanding SARC services and forensic medical skills around the country

Other developments here would rely upon the vision and ambition of partners, as well as developments in other leading Centres, such as St Mary's and The Havens.

Drawing on the above, the recommendations from the needs assessment are summarised in the box below:

Recommendations

Developing services is a task for partners. Current policy emphasises the commissioning roles of the NHS, the Police, and – given forthcoming responsibilities for public health (and sexual health within that) - local authorities. Specialist voluntary sector organisations have a key role as service providers and advocates for victims.

The main considerations for commissioners are: what they understand their organisational remit to be; how ambitious they are for the development of these services; and therefore how far they are prepared to invest resources in their improvement (relative to other investments they currently make).

The overall recommendation from this study is to take the Options presented above as a framework for the development over time: starting with action to meet minimum standards, but progressing to become a centre of excellence. *Therefore...*

...in the immediate term (within the next year):

- Formally establish an agreed set of pathways – for both adults and children and young people. All agencies involved should then support the coordination of services against these pathways. Awareness raising across services is critical.
- Introduce 24 hour crisis support workers at the SARC. Developing pooled budgets / joint commissioning arrangements is appropriate here and could give better value for money by reducing transactions costs.
- Combine GUM and other health services with the current FME service.
- Strengthen clinical governance by appointing a clinical director.
- Work to develop self-referrals (once an improved service has become established).
- Review current children and young people's services with a view to aggregating FME services into fewer, more specialist, NHS Trusts.
- Undertake a feasibility study to examine the possibilities for new facilities - most likely in Birmingham. Children / young people's services should be included in this.

...in the medium term (next two-three years):

- Fully develop joint commissioning / governance arrangements; commission services, such as the ISVA, where there are gaps.
- Commission evidence-based programmes to promote prevention, e.g. in schools.
- Move into new facilities.
- The SARC should become a hub for intelligence on sexual violence.

...in the longer term:

- Become a centre of excellence.


Finally, and in summary, this report provides an evidence base for action. Many of the issues raised are not new: they have been known since the NST visit in 2009. The requirements of policy and practicality demand a partnership-based approach: no single organisation can deliver the required improvements. Partners must therefore understand their remit and priorities in relation to sexual violence and invest accordingly.





There are several sources of uncertainty in doing so. Notably this includes: the planning and commissioning of services where 'demand' could vary significantly given the high levels of potential unmet need; and, the current policy and funding environments facing partner organisations.




Nevertheless, there is sufficient evidence to act and sufficient urgency to do so without delay. Moreover, through the Business Case developed alongside this needs assessment, there is a detailed guide to action.



The nature of the issue facing partners is therefore practical. Individual organisations are required to commit to collective action and the joint funding of services. Mechanisms are now in place for this to happen – notably through the strategic and operational groups that have formed around the SARC. These structures are important, but improvement relies upon the commitment of the individual organisation represented. It is at this level where the next steps must be taken.

Annex 1 Summary of West Midlands services against national minimum standards for SARC


Services for Adults		
Standard	Assessment	The current facility
<p>24 hour access, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.</p>		<p>Twenty-four hour access: The Castle Vale Rowan Centre is manned from 7-4.30, and the Walsall Rowan Centre is manned from 8-12, from Monday to Friday. Outside of these hours, and on the weekend, Police access to the centres is available, but there is no crisis or administrative support available. Twenty-four hour access is therefore only available for those victims who are referred by the police.</p> <p>Self-referrals: Self-referrals are very rare. Most referrals to the SARC come from the Police, and a small number also come from support agencies in the region.</p> <p>Crisis Support: There are no dedicated Crisis Workers at the Rowan Centres. These duties are performed to some extent by three members of staff. However this is included amongst their other administrative duties of ensuring day-to-day running of the centres. Often the team is short-staffed and one member of staff is required to cover both centres.</p> <p>Specialist forensic and clinical care in a secure unit: There are dedicated FME suites suitable for collecting forensic evidence. This provision does not however cover clinical care, and medical needs are not catered for in the centres.</p> <p>First aid and Safeguarding: Both centres support personal safety. Police protocols are in place with the centres to initiate adult safeguarding procedures where required.</p>

<p>Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant, throughout the examination process.</p>		<p>There are no dedicated Crisis Workers at the Rowan Centres. These duties are performed to some extent by the Operations Managers and Strategic Manager. However this is included amongst their other administrative duties of ensuring day-to-day running of the centres.</p>
<p>Choice of gender of physician wherever possible.</p>		<p>There is no choice of gender for FMEs offered to Rowan Centre service users, and there are a limited number of females (four out of 38) on the rota here.</p>
<p>Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.</p>		<p>Primecare Forensic Medical is contracted by the Police to conduct the forensic medical examinations for the whole of the West Midlands as part of a block 'offender healthcare' contract. As such, most of the doctors work with perpetrators of crime for the majority of their time. Some of the doctors however only work with sexual violence victims. The Primecare service is a 24-hour rota-based service, where doctors work 12 hour 'on-call' shifts. While they are on call they are not involved in any other work. The response time from initial call to examination is 1 ½ hours.</p> <p>Clinical governance of the FME service remains an issue. 'Internal governance' is provided by Primecare who have removed a number of doctors from the rota following complaints.</p> <p>Scientific governance is currently in place in the form of feedback from the Forensic Science Service on the quality of evidence provided. There is an FME sub-group (set up as a temporary measure) providing some oversight, which has improved the quality to some extent, however concerns regarding the consistency of the service remain.</p>
<p>Dedicated, forensically approved premises and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a</p>		<p>There are three dedicated FME suites suitable for collecting forensic evidence; 1 at the Castle Vale centre and two at the Walsall Centre. The 2009 NST review of the West Midlands response to sexual violence commended overall forensic integrity at both centres, but</p>

<p>robust chain of evidence.</p>		<p>noted that a clear generic decontamination policy is absent. There are still some concerns over the quality of evidence submitted.</p>
<p>The medical consultation includes a risk assessment of harm/self harm, together with an assessment of vulnerability and sexual health; Immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.</p>		<p>Services for at the Rowan Centres focus on the forensic evidence collection of a Police investigation; there is limited assessment and immediate treatment of health issues as recommended by this standard. The doctors on the current FME rota have inconsistent skills to meet this requirement.</p> <p>Post exposure prophylaxis treatment is not available at the Rowan Centres, and the availability of emergency contraception is inconsistent and dependent on the doctor on call. Referral pathways to ensure access to health services are patchy - although there is a fast track route into GUM services ('opt out') for Birmingham. There is very limited assessment of mental health/self-harm or safety at the SARC.</p>
<p>Access to support, advocacy and follow-up provided through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process, should the victim choose that route.</p>		<p>This is available through referrals of all victims attending the centres, to specialist agencies for the ISVA support housed here. There is now an 'opt out' agreement in place for these referrals.</p> <p>There are some concerns that the ISVA service is stretched in terms of capacity, and that waiting lists can be long, and there are some geographical gaps based on the localised model of the service.</p>
<p>Well co-ordinated interagency arrangements are in place, involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.</p>		<p>Limited interagency arrangements are in place - chiefly between the centres and GUM/ISVA services. Referrals to GUM services may not always be appropriate across the region however, as the arrangement is currently only with the Hawthorne House clinic in Birmingham; there are plans to have similar arrangements with all local clinics, with Hawthorne House remaining the lead organisation.</p> <p>Information sharing between the specialist third sector agencies and the Rowan Centres is problematic. Information sharing of intelligence on offenders and locations are in place with the sex worker project,</p>

		SAFE. This intelligence is shared via the 'ugly mugs' scheme and is passed onto the Police via the SARC.
The SARC has a core team to provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.		There is no 24/7 coverage of staff at the centres, although the facilities are available for access by the Police to arrange FMEs out of hours.
A minimum dataset and appropriate data collection procedures in each SARC.		<p>Data systems are now in place, and recording has improved since October 2010. Data routinely collected includes incidence (and day of week), location, gender, ethnicity, and age of victims attending, the referral source, and onward referrals to GUM and ISVA services. Data on drugs/alcohol, and domestic violence related incidence is also recorded. There is also a good link with the SAFE project for sex workers in Birmingham, to record incidence in this group via the 'ugly mugs' scheme.</p> <p>However, there is not a SARC information policy nor is there governance in place for data collection, and information procedures do not comply with legal or NHS policies. Data collected is defined by priorities for the Police and a partnership approach to collecting, sharing and reporting on data is missing; there are no information sharing agreements in place between partner organisations and the SARC.</p>

Services for Children and Young People

Standard	Assessment	The current facility
Twenty-four hour access, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.		Twenty-four hour access: CYP may receive FMEs at Rowan Centres (from age 13) or from paediatricians across the West Midlands. 24 hour cover is available at the Oasis suite (Children's Hospital) and Heartlands Hospital for children in Birmingham. Outside Birmingham

provision can be patchy and dependent on the availability of local paediatricians.

Crisis Support: There are no dedicated Crisis Workers at the Rowan Centres or at the alternative paediatric services. CYP may be accompanied by a Social Worker and their parents/guardian.

Specialist forensic and clinical care in a secure unit: There are dedicated FME suites suitable for collecting forensic evidence at the Rowan Centres. Facilities in paediatric services within Acute Trusts across the region are inconsistent, and the forensic integrity of these facilities is uncertain. CYP seen by paediatrics are more likely to have their health needs met as opposed to those seen for just an FME in the Rowan Centres.

First aid and Safeguarding: How well the facilities support personal safety, and cater for safeguarding and first aid needs is not clear.

Appropriately trained crisis workers to provide immediate support to the victim and significant others where relevant, throughout the examination process.



There are no dedicated Crisis Workers at the Rowan Centres or at the alternative Paediatric Service facilities for CYP.

Choice of gender of physician wherever possible.



A female paediatrician is not always available, there is no choice of gender for FMEs offered to Rowan Centre service users, and there are a limited number of females (four out of 38) on the rota here.

Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.



Primecare Forensic Medical is contracted by the Police to conduct the forensic medical examinations for the West Midlands. Primecare cover all FME sites in the region, and all ages. When the victim is under 16 years the forensic medical examination is sometimes conducted jointly with a paediatrician. Generally, if the child is over 13 years (especially if they have been sexually active) then the paediatrician will not attend and the Primecare doctor will conduct the examination alone.

Levels of engagement of paediatricians across the region vary, with children from some areas having to be seen outside of their local area. There is no statutory obligation on paediatricians to conduct sexual offence examinations, and the availability of this service across the West Midlands is therefore inconsistent.

Dedicated, forensically approved premises and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a robust chain of evidence.







Children's FMEs are conducted either at the SARC or at one of seven facilities within Acute Trusts across the West Midlands. The services at the Rowan Centres are adult services and do not meet standards to ensure they are CYP friendly, as per DOH criteria for CYP friendly health services, (DOH, 2007).

The paediatric facilities across the West Midlands are not well linked to each other or the SARC. There are two dedicated suites for child abuse across the West Midlands; the 'Oasis Suite' at the Birmingham Children's Hospital, and the 'Starfish Centre' at Walsall Hospital. At the other five sites, CYP are usually seen in general out-patients' rooms; at Solihull Hospital this is a 'quiet space' away from the main outpatients department. The forensic integrity of these sites has not been reviewed to date, and there are no decontamination protocols in place.

The medical consultation includes a risk assessment of harm/self harm, together with an assessment of vulnerability and sexual health; Immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.



Services for CYP seen at the Rowan Centres focus on the forensic evidence collection of a Police investigation; there is limited assessment and immediate treatment of health issues as recommended by this standard. The doctors on the current FME rota have inconsistent skills to meet this requirement. Post exposure prophylaxis treatment is not available at the Rowan Centres, and the availability of emergency contraception is inconsistent and dependent on the doctor on call. Referral pathways to ensure access to health services are poor, and there is very limited assessment of mental health/self-harm or safety at the SARC.

		<p>CYP seen in paediatric services are offered a more detailed examination and assessment of health needs, with good systems in place for referral/treatment of health related problems (e.g. GUM health). How well mental health services interface with paediatrics services is less clear.</p>
<p>Access to support, advocacy and follow-up provided through an independent sexual violence adviser (ISVA) service, including support throughout the criminal justice process, should the victim choose that route.</p>		<p>There are only two dedicated Children's ISVAs (Sandwell and Walsall), and there is provision from the age of 11 years upwards from three other ISVAs (Coventry). However the support for children from these ISVAs will be limited to geographical areas (i.e. Sandwell, Walsall, and Coventry). Support through the criminal justice system is not always consistent, as one-to-one support when there is a pending court case is sometimes considered to risk 'contaminating evidence'. This is a particular gap for very young children between the ages of 2-7 years.</p>
<p>Well co-ordinated interagency arrangements are in place, involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.</p>		<p>The 2009 NST review of response to sexual violence in the West Midlands concluded that interagency arrangements are unclear between the Police, the NHS, and children and family services.</p>
<p>The SARC has a core team to provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.</p>		<p>There is not 24/7 coverage of staff at SARC, and inconsistencies across alternative CYP facilities in paediatric services.</p>
<p>A minimum dataset and appropriate data collection procedures in each SARC.</p>		<p>There is limited data collection in place, and there is no shared agreement between the FME sites regarding data that should be routinely collected. Accurate prevalence data of sexual abuse in the West Midlands is therefore limited.</p>

Annex 2 Bibliography

A comprehensive bibliography of sources used is provided in the full report; here only the small number of sources referred to directly in this summary are listed:

- Burton et al (2010) *Sexual Assault Referral Centre Health Needs Assessment*. Nottingham
- Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect*. NSPCC: London
- Department of Health (2011) *Response to Sexual Violence Needs Assessments Toolkit (Revised): Informing the commissioning and development of co-ordinated specialist services for victims of sexual violence*. London
- Department of Health, Home Office and the Association of Chief Police Officers (2009) *A Resource for Developing Sexual Assault Referral Centres (SARCs)*. London
- NSPCC website: 'Statistics on sexual abuse, July 2011'
- Valenti-Hein, D. & Schwartz, L. (1995) *The sexual abuse interview for those with developmental disabilities*. Santa Barbara: California.
- Wolff, N et al (2008) *Contextualization of Physical and Sexual Assault in Male Prisons: Incidents and Their Aftermath*. Journal of Correctional Health Care January, 2009
- Zimmerman, C et al (2006) *Stolen smiles: The physical and psychological health consequences of women and adolescents trafficked in Europe*. The London School of Hygiene and Tropical Medicine: London

Annex 3 Summary of method

A full description of the method used for the needs assessment can be found in the technical report, but in summary the following tasks were used to generate evidence for the study:

- Call for data and information. It was anticipated that individual organisations working in this field would also hold data relating to their services, or through specific pieces of research they have undertaken. A general 'call for information' was therefore issued. This was run by email, with a specific email address, and asked for information against a standard template. Organisations were encouraged to forward the email on to create a 'snowball' sample. Around 150 organisations were contacted and around 50 responded.
- Consultation with stakeholders. In total 31 stakeholders were consulted; these were drawn from key partner organisations across the West Midlands. These stakeholders represented local authorities, the Police, the health sector and voluntary organisations working in sexual violence services. These stakeholders were consulted with in the form of telephone and face-to-face semi-structured interviews. A focus group was also held with 7 attendees.
- Consultation with survivors. Five survivors were recruited to take part in semi-structured interviews to discuss their experiences of accessing services, and how they considered these could be improved. Survivors who had received support over a year ago and who were no longer pursuing criminal investigations, were also consulted.
- Analysis of standard statistical data. Primarily, this was used to estimate the potential scale of need. The main source used was the British Crime Survey, which was selected in order to best address the problems of under-reporting / low levels of service access present in alternative sources. Data derived from these national estimates were then weighted to account for the different demographics within the West Midlands' local authority areas.
- Review of policy and other SARC models. Finally, policy in this area was reviewed, and short case studies of other SARCs were produced.