Sexual Abuse

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Executive summary

Introduction

Sexual abuse is experienced by 19.1% of women and 2.7% of men over the course of their lives[1]. Sexual abuse is often a feature of domestic or intimate partner abuse and has the same common feature: that of perpetrators achieving power and control over their victims. Most of the time, victims know the person perpetrating the abuse and despite this fact, sexual offences are crimes with low levels of reporting and low levels of conviction through the courts.

Recent research has identified that responding to sexual and physical abuse is a priority across the health service[2].

All ages and both genders are affected, but for the purposes of this Needs Assessment we are looking at male and female adult victims of recent or historical abuse, and teenagers (13 – 18 years) affected by, or at risk from, sexual abuse in intimate relationships. That is to say this needs assessment does not address child sexual abuse by family, carers, or professionals since this is covered elsewhere by the Nottinghamshire Safeguarding Children's Board

Current trends include:

- a significant rise in reports of historical abuse since 2012, when a number of high profile historical sexual abuse cases appeared in the media, and

[1] Crime Survey England & Wales

[2] *Professor Sir George Alberti - Taskforce report on Responding to Violence Against Women and Children – the role of the NHS (2010)*

- a growing awareness by parents and educators of the risks to young people from sexual abuse often linked to social media and digital communication

Unmet need and gaps

Disclosure of sexual abuse is low. Just above 1 in 10 victims report to the Police. Others disclose in confidence to specialist support services long after the event. Many tell no-one about their experiences. Services do exist in Nottinghamshire for both men and women, and for teenagers from the age of 13. These services support the current demand with managed waiting lists. The potential demand from undisclosed abuse is estimated at more than twice the current level of demand[3]. Since support services are already stretched with the current level of activity, and dependent upon short term funding arrangements to survive, there is no existing capacity to increase services if demand continues to rise.

There is an absence of carefully planned and properly resourced Direct Enquiry programmes in mainstream services. These need to be supported by specific training on sexual abuse to ensure survivors know they are safe to disclose and are supported following disclosure.

Prevention work with young people is not routinely available in schools or youth projects. Young people at risk are not always identified and supported. (There are links here with the work on sexual exploitation which is led by the Nottinghamshire Safeguarding Children's Board)

There is a local shortage of male specialist sexual abuse counsellors and the is a lack of specialist therapists in mainstream mental health services.

Recommendations for consideration by commissioners

In the context of limited finance, the emphasis over the next period will be on improving the provision from mainstream health and criminal justice services to encourage earlier disclosure of sexual abuse and implement appropriate support to support victims. Where possible, Nottingham City and Nottinghamshire County Council will work together to avoid duplication and develop services that meet the needs of local residents.

Recommendations are grouped under four headings:

1. Prevention to reduce levels of sexual abuse in the population.
    - Promote media campaigns that challenge harmful gender stereotypes and sexualisation of young people. Use the media to encourage greater awareness of risk and publicise the benefits of support services.
    - Encourage safeguarding leads in schools to identify young people at risk from sexual exploitation and harmful relationships and signpost them to services that will engage these young people in learning protective behaviour and understanding of risk
    - Work with commissioners of children's services to ensure Healthy Relationships Education is included in the "Mainstream Offer" to all schools.

[3] See table 4 page 9

- Support the research proposal for a longitudinal study of Healthy Relationships Education for young people to test whether knowledge, understanding and attitude change are sustained over several years[4].

2. Improved awareness and identification of sexual abuse by mainstream services
   - Ensure criminal justice, mental health, social care and primary care service providers are aware of sexual abuse and how to respond and signpost appropriately.
   - Clarify and support the implementation of routine and selective enquiry about sexual abuse in identified mainstream services to increase identification and disclosure. (Recognising that prior training is essential for successful implementation)
   - Analyse existing information from specialist services, Health and Police into a quarterly data report on sexual abuse
   - Include sexual abuse as an element in the Human Resource support programmes of partner agencies. Eg The Workplace Health Scheme being developed by Nottinghamshire County Council

3. Support and access to services for survivors of recent or current sexual abuse and for survivors of historical sexual abuse
   - Promote the support services in Nottinghamshire through the widespread use of the 24 Hour Freephone Domestic and Sexual Violence Helpline information cards available free to all agencies, and targeting mainstream NHS services that survivors already access.
   - Work with mental health commissioners to address waiting times for access to psychological therapies and the availability of specialist counselling services. Developments to include a consistent approach to measuring outcomes for counselling services.
   - Work with the Nottinghamshire Police and Crime Commissioner and NHS England to ensure that Nottinghamshire SARC is commissioned successfully with adequate staffing
   - Ensure services can safely meet the needs of both male and female survivors of sexual abuse

4. Criminal Justice
   - It should be recognised that effective investigation and prosecution of sexual assault and rape are key to building the confidence victims need to disclose sexual abuse.
   - The criminal justice agencies have a number of plans in place to improve their procedures. These should be linked with the work of other partners using the existing Safer Nottinghamshire Board and Health and Well-Being Board structures

[4] *Equation proposal to undertake research with a local university*

Full JSNA report

What do we know?

1. Who is at risk and why?

1.1 What do we mean by Sexual Violence?

For the purposes of this document the terms 'Sexual Abuse' and 'Sexual Violence' are used inter-changeably. 'Sexual Abuse' is generally preferred because it is thought to cover a wider range of behaviours than 'Sexual Violence'. However as the definitions below show, sexual abuse is included in sexual violence by key agencies.

According to the UK Department of Health:
Sexual violence *covers a wide range of abusive acts directed towards an individual's sexuality, including sexual assault, rape, sexual coercion, sexual bullying and female genital mutilation*[5]*.*

The World Health Organisation defines **Sexual Violence** as:
any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work[6]*.*

1.2 The Impact of sexual violence

The Department of Health set out the scale of the challenge facing the Government on this issue in 2012:[7]

- Sexual assault is a criminal offence[8].
- Sexual assault affects people of all genders, cultures and age groups.
- Sexual assault is commonly committed by perpetrators known by the victims, and in the case of child sexual abuse, it is often intra-familial.
- Around 10,000 women are sexually assaulted and about 2,000 women are raped every week.[9]
- As few as 11% of those who have been raped tell the police.
- More than one third (36%) of all rapes recorded by the police are committed against children under 16 years of age.
- 16% of children under 16 experienced sexual abuse during childhood (11% of boys and 21% of girls).
- The Home Office estimates that the cost of violence against women and girls to society is around £36.7 billion. However, this does not take into account the long-term emotional and mental health problems experienced by victims or the fact that many of these crimes go unreported and undetected each year. The true cost is likely to be much higher.

[5] Protecting People Promoting Health DH 2012
[6] www.who.int/violence_injury_prevention/violence/.../chap6.pdf
[7] Response to Sexual Violence Needs Assessments (RSVNA)Toolkit (Revised) DOH 2011
[8] See Appendix A :- Sexual Violence Definitions in the law
[9] Self-reported, as part of the British Crime Survey

The NHS has recognised through recent research that responding to sexual and physical abuse is a priority across the health service[10].

> *"The NHS spends more time dealing with the impact of violence against women and children than almost any other agency. Physical and sexual violence and abuse have direct health consequences and are risk factors for a wide range of long-term health problems, including mental health problems, alcohol misuse, trauma (including maternal and foetal death), unwanted pregnancy (including teenage pregnancy), abortion, sexually transmitted infections and risky sexual behaviour…. more women suffer rape or attempted rape than have a stroke each year… The same effort to ensure that a heart attack victim or a stroke patient gets rapid and appropriate care should be applied to the victims of violence and abuse."*

Similarly the Home Office has recently updated its Violence Against Women and Girls Strategy saying:

> *"We are determined to support victims in rebuilding their lives, reporting these crimes, and to make sure perpetrators are brought to justice. We all need to do more to prevent violence against women and girls happening at all."*[11]

Recent years have brought an increase in disclosure of sexual abuse, however, given the size of the issue, confidence to report sexual abuse remains low. This is due to a variety of factors including:

- the intimate nature of the crime which carries both shame and self-blame for many victims,
- the very low conviction rates achieved after sometimes traumatic court experiences, and
- the social consequences of disclosure which may impact on partners, parents, children and relationships at work

The overarching principle, now generally shared by partners engaged on this issue is that:

> *The risks to the mental health of victims of non-disclosure as well as the risks to the community of further violence from unidentified perpetrators, provide the reasons why increasing disclosure is in everyone's interest.*

1.3 Who is at risk?

Department of Health 2012[12] identified the following risk areas and data:

- Men, women and children are all at risk from sexual abuse.
- Women are at five times greater risk than men.
- Young women 16-19 are the age group with the highest reported sexual abuse.
- Sex workers and gay and bisexual men are also at increased risk.

Over 400,000 women and 80,000 men in England and Wales are estimated to have suffered a completed or attempted sexual assault in the past year. In 2011/12, 53,665 sexual offences were recorded by police in England and Wales, including around 16,000 rapes and 22,000 sexual assaults. The remaining 15,665 were classified as less serious

[10] Professor Sir George Alberti - Taskforce report on Responding to Violence Against Women and Children – the role of the NHS (2010)

[11] Home Office Website . Ending violence against women and girls in the UK Updated 2012

[12] Protecting People Promoting Health DH 2012

offences including voyeurism, exposure and sex with minors. One in three rapes recorded by police involved child victims under the age of 16. Sexual violence is known to be widely under-reported, with only one in ten adult victims of serious sexual assault reporting the incident to police.

The Crime Survey England and Wales includes a self-completed module to gather data on sexual assault experienced by adults. In 2011/12 it estimated that around one in five women (19.6%) and 2.7% of men had suffered a sexual assault since the age of 16. 3 % of women and 0.3% of men reported an actual or attempted sexual assault in the previous year, equating to around half a million adult victims.

The perpetrators of serious sexual assault are most often known to victims. Over half of female victims in 2009/10 were assaulted by partners or ex-partners. Only 14% were assaulted by strangers. Conversely, most of the less serious sexual assaults reported to the Police such as indecent exposure and sexual threats were committed by strangers (see 2.4 figure 3).

Alcohol is a common feature in sexual assault. Over a third of offenders and a quarter of victims of serious sexual assault are thought to have consumed alcohol prior to the incident. (It is also worth noting here that nearly two thirds of offenders were not thought to be influenced by alcohol)

Common myths promote negative attitudes towards female victims of sexual violence[13], particularly if they have been drinking, using drugs or dating the perpetrator prior to the assault.

Sexual violence can also manifest through forced marriage, human trafficking and Female Genital Mutilation (FGM). The extent of all these forms of violence is largely unknown and so estimates should be treated with caution. Police research in 2009 estimated that 2,600 trafficked women were involved in off-street prostitution markets across England and Wales. A 2007 study estimated that 66,000 women in England and Wales had FGM, and 33,000 girls were at high risk of existing or future FGM.

2. Size of the issue locally

For ease of reference sexual offences are divided into two categories:

Serious sexual offences covering all sexual assault, rape and attempted rape offences

Other sexual offences covering exposure, voyeurism and sexual activity with minors [excluding sexual assault and rape].

[13] http://www.rapecrisis.org.uk/commonmyths2.php

Table 1: Sexual Abuse reported to Nottinghamshire Police in 2013 by District and Assault Category

District *Location where incident took place*	Serious	Other sexual	Total
Ashfield	88	16	104
Bassetlaw	77	14	91
Broxtowe	39	17	56
Gedling	61	7	68
Mansfield	104	19	123
Newark & Sherwood	59	21	80
Rushcliffe	33	10	43
Total for Nottinghamshire County	**461**	**104**	**565**

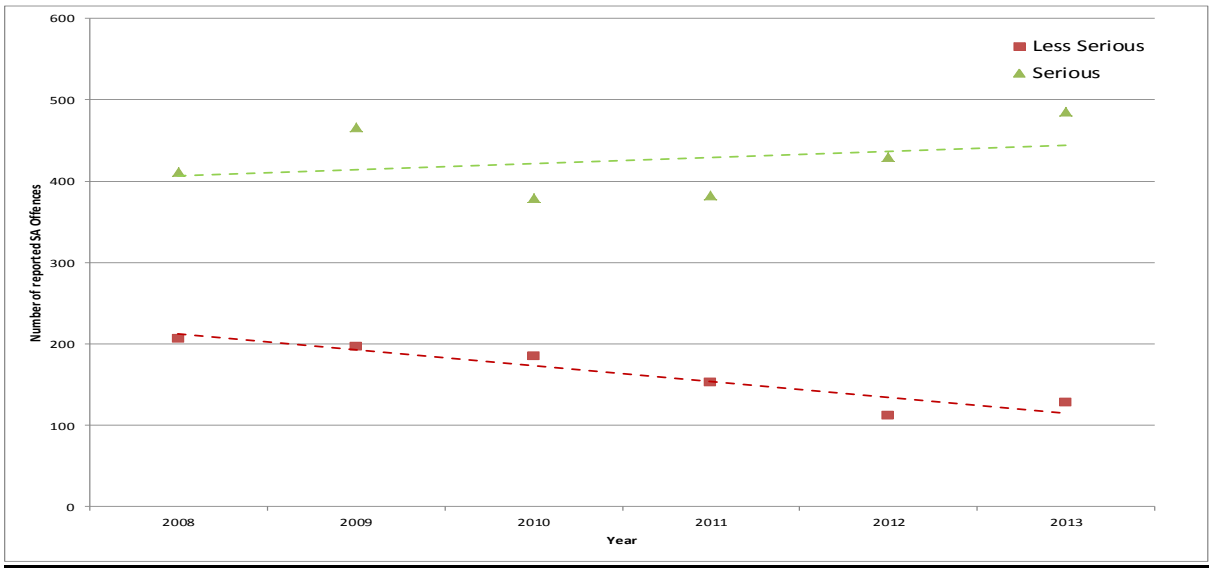
Source: Nottinghamshire Police

2.1 Is sexual violence increasing in Nottinghamshire?

The picture is mixed. We cannot confidently say that sexual offending is increasing in Nottinghamshire although a greater number of serious sexual offences are being reported to the Police.

Figure 1 below shows the trends in offences reported to Nottinghamshire Police, between 2008 and 2013. Serious offences have increased over the last five years from approximately 400 to nearly 500 per annum. Other (Less Serious) sexual offences have decreased over the same period from 200 offences to around 120.

Figure 1 Trend in offences in Nottinghamshire reported to Nottinghamshire Police 2008-13



Source: Nottinghamshire Police

The Crime Survey for England and Wales shows at a national level that there has been no clear pattern of increase or decrease over the same five years. Each year between 0.4 and 0.5 percent of males and between 2.0 and 3.0 percent of females report experiencing one or more serious sexual offences. The data for other sexual offences ranges from 0.3 to 0.4 percent of males and 1.8 to 2.7 percent of females.

What is clear is that most sexual offences are not known to the Police because reporting levels are very low. The section below will demonstrate what we know about the gap between actual prevalence and reported incidents

2.2 Is there significant unmet demand as a result of low levels of disclosure? How many victims would we expect if all were known?

Lifetime experience of sexual assault shows 2.7% of men and 19.6% of women have been victims of one or more sexual assaults. However please note that the crime survey question only relates to those people under 60.

Table 2 & 3 below contain estimates of prevalence by District. These have been calculated using the national data from the Crime Survey Survey England and Wales and adjusting for known local variation in social and economic factors. There are approximately 3 times as many other/less serious sexual offences than serious ones

Table 2: ESTIMATES of prevalence by District of OTHER/LESS SERIOUS sexual offences in the past year among adults aged 16-69 years 2012/13

Resident populations aged 16-59	Male	Female	Total
Ashfield	119	597	716
Bassetlaw	111	517	628
Broxtowe	111	548	659
Gedling	109	550	659
Mansfield	105	529	634
Newark and Sherwood	111	505	616
Rushcliffe	109	525	632
Nottinghamshire County Total	775	3,771	4,544

Source: Nottinghamshire Public Health Intelligence Team using Crime Survey England and Wales

Table 3: ESTIMATES of prevalence by District of SERIOUS (incl attempts) sexual offences in the past year among adults aged 16-69 years 2012/13

Resident populations aged 16-59	Male	Female	Total
Ashfield	48	164	212
Bassetlaw	45	142	187
Broxtowe	45	151	196
Gedling	44	151	196
Mansfield	42	146	188
Newark and Sherwood	45	139	184
Rushcliffe	43	145	188
Nottinghamshire County Total	310	1,038	1,350

Source: Nottinghamshire Public Health Intelligence Team using Crime Survey England and Wales

By comparing these local estimates of the actual volume of sexual offending and the Police crime data on reported incidents it is possible to calculate that aproximately 11% of sexual offending in Nottinghamshire in 2013-14 was reported to the Police. The proportion of serious offences reported is much higher 37.56% than that for other sexual offences 2.71%. (See Table 4)

Table 4: Comparison of reported crimes by type compared to expected number of offences

	Serious	other sexual	All Incidents
All Nottinghamshire predicted number of sexual offences	1,350	4,544	5,894
Reported crimes in the County recorded by the police in 2013	461	104	565
Percentage known to the Police	34.15%	2.29%	9.59%

Data: Police and Crime Survey England and Wales

From these it is possible to estimate that the potential demand for services (from previously undisclosed sexual abuse) is at least twice the current level of demand.

2.3 Is Nottinghamshire showing a picture of disclosure, investigation and conviction that matches the national picture?

The Public Health Outcomes Framework has two outcome measures related to this agenda. One is specifically regarding sexual violence; the other includes all violent sexual offences. All our Districts with the exception of Mansfield have lower rates than the England and East Midlands rates (re Table 6 below). The rate of sexual offences is aligned to the all violence figure collated in the Public Health Outcomes Framework with the exception of Broxtowe which has a lower ratio.

Table 5 Public Health Outcomes Framework Indicators for reported Violent Crime data, 2012-13

Public Health Outcome Measure (expressed as a rate per 1,000 population)	**England**	**East Midlands**	**Nottinghamshire**	**Ashfield**	**Bassetlaw**	**Broxtowe**	**Gedling**	**Mansfield**	**Newark & Sherwood**	**Rushcliffe**
1.12iii) Violent crime - Rate of sexual offences	0.83	0.80	0.58	0.73	0.71	0.35	0.53	0.89	0.58	0.30
1.12ii) Violent Crime - All violence offences	10.6	10.4	9.1	11.1	9.8	7.0	8.3	**14.9***	8.3	4.2
Ratio Sex offences to all violence	0.08	0.08	0.06	0.07	0.07	**0.05***	0.06	0.06	0.07	0.07

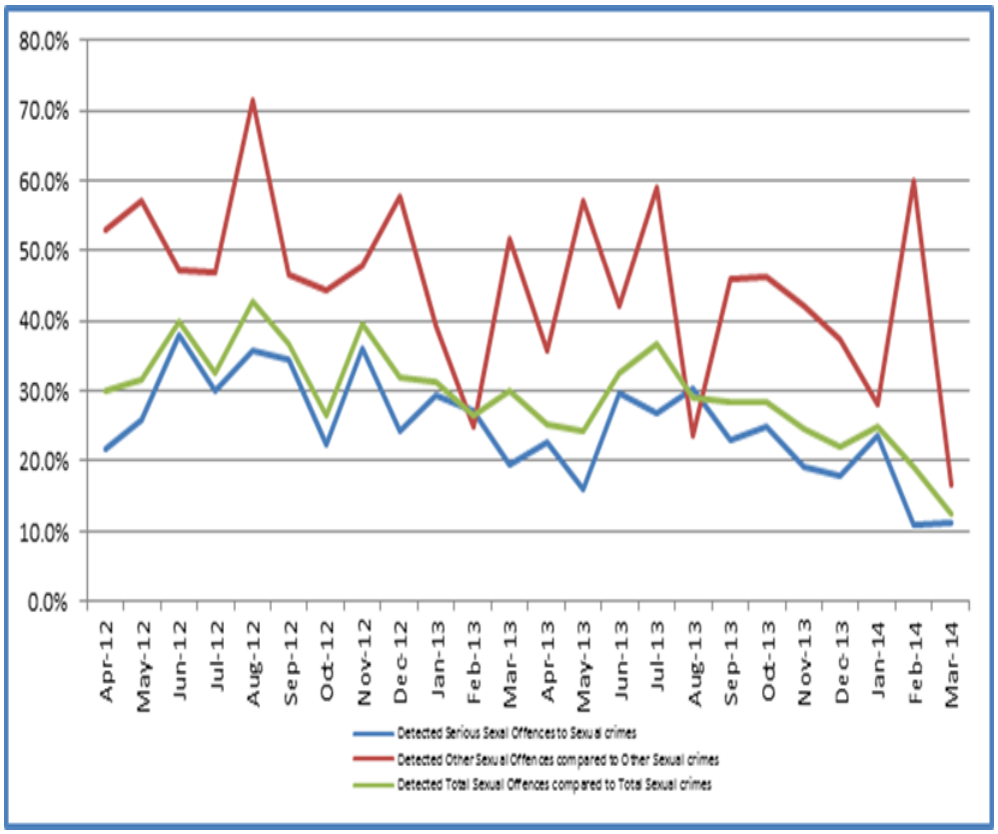
Source: Public Health England

iQuanta data (restricted so not published here) for Sexual Offences enables comparisons to be made at the level of Community Safety Partnerships (CSPs) . All Nottinghamshire CSPs show lower than average rates of reported sexual offending as compared to their Most Similar Groups (MSGs). It is not clear whether this is because there is less reporting to the police or less actual offending.

Detection and Charging

Figure 2, shows the level of serious sexual offences to those detected, the level of other sexual offences to those detected and the level of total detections compared to serious sexual offences. There is little evidence to suggest that the increase in reporting is resulting in more offences charged. As the levels of sexually reported crimes are increasing, and the detection rates for all three of these measures are reducing.

Figure 2 Trends in Detection Rates for Sexual Offences in Nottinghamshire 2012-14



Source: Nottinghamshire Police

The green trend line shows the general trend of total sexual offences (detected) to total sexual offences (crimes) is decreasing.

Prosecution of sexual offences

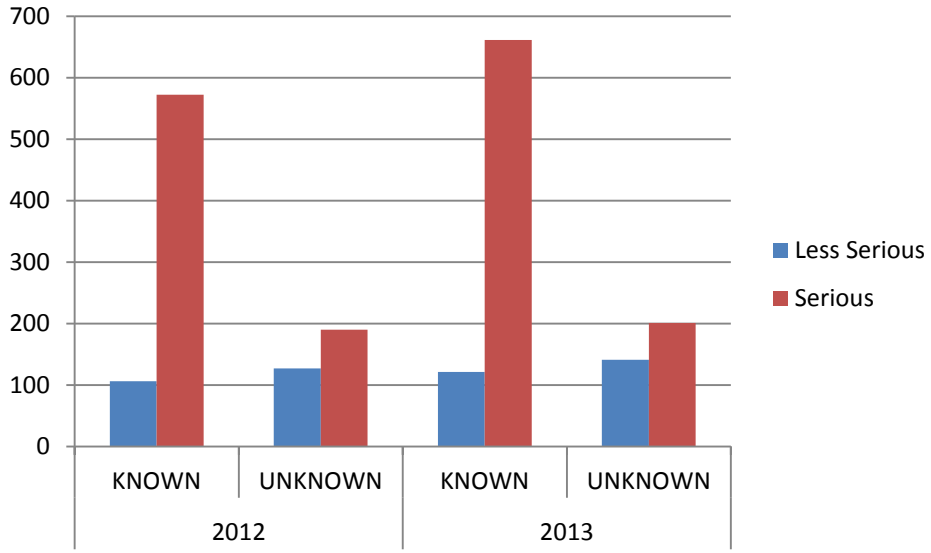
Nottinghamshire has a better than average record for successfully prosecuting sexual offences. It was ranked 5th out of 42 Crown Prosecution areas in Quarter 1 and 18th out of 42 in Quarter 2 of 2013-14. However Nottinghamshire Crown Prosecution Service carries a lower sexual offences caseload than many other areas. In 2013-14 Nottinghamshire CPS was ranked 36 out of 42 areas in Quarter 1 and 32 out of 42 areas in Quarter 2 for its

sexual offences caseload. Thus in Nottinghamshire it may be harder to get a case to court than elsewhere but then the case is more likely to proceed and be successfully concluded.

2.4 What is known about the relationship between the victim and perpetrator

Most serious sexual offences are committed by people known to the victim. This can be seen in Fig 3. This is in contrast to the other sexual offences when the perpetrator is unknown in the majority of cases. This may be because these are "less serious" sexual offences which are unlikely to be reported when the parties know each other.

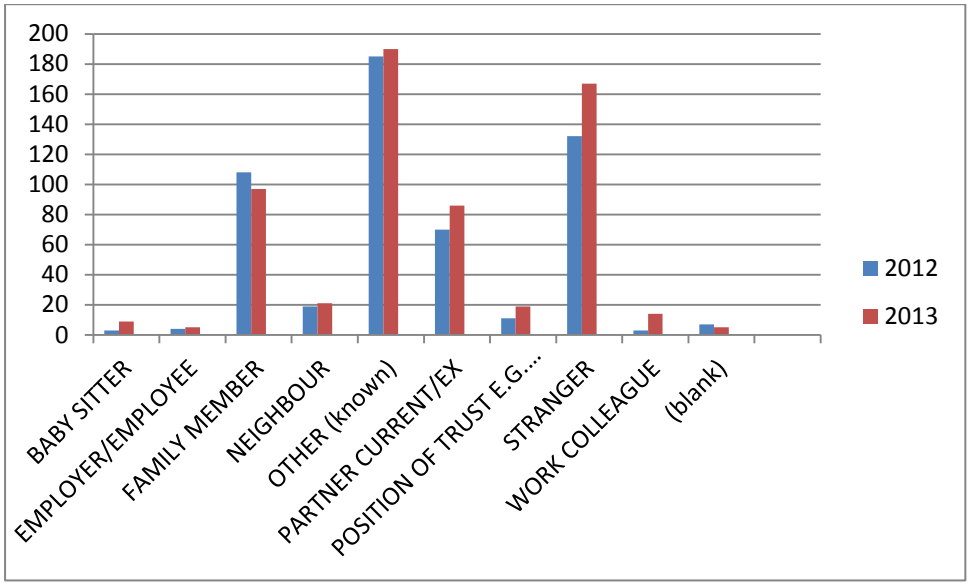
Fig 3 Number of Perpetrators known or unknown by category of offence Nottinghamshire 2012 &13



Data Nottinghamshire Police

Further details about the victim offender relationship are shown in Table 7

Fig 4 Perpetrator victim relationship by number of cases Nottinghamshire 2012-13

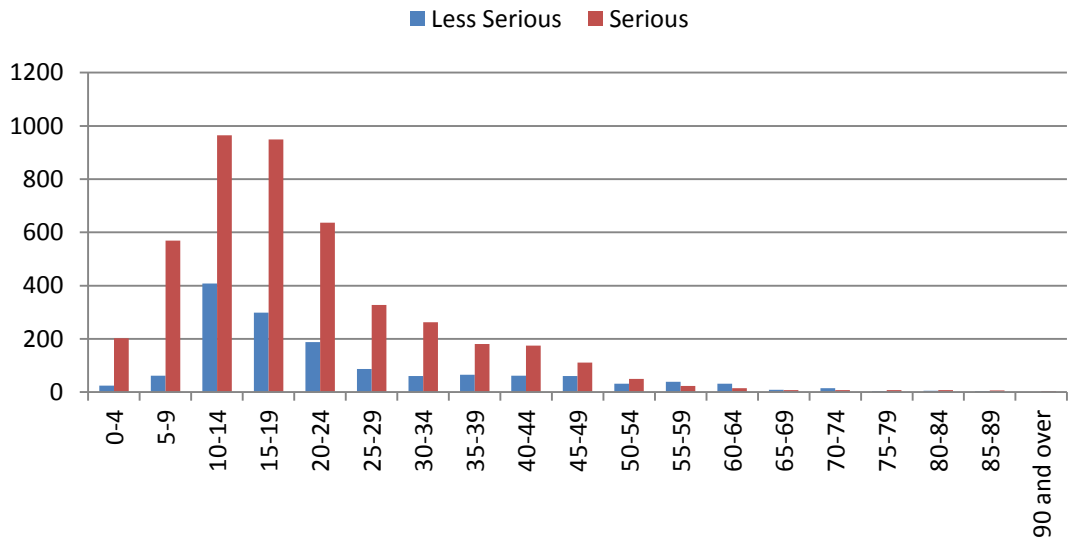


Data Nottinghamshire Police

2.5 What else do we know about sexual abuse in Nottinghamshire?

Police reporting shows that people are most at risk between the ages of 10 and 25 years (see fig. 5) . *Caution: This evidence from Police reporting may not reflect actual abuse across the age ranges.*

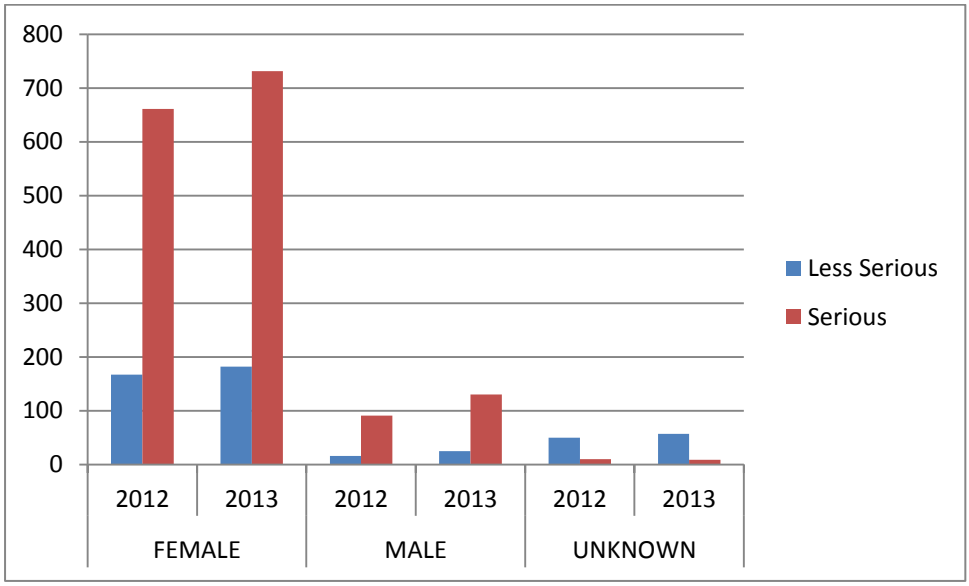
Fig 5 Age group by number of victims reported to Notts Police 2008-2013



Data Nottinghamshire Police

The majority of victims reporting to the Police are female although there is a significant male victim cohort reporting sexual abuse.

Fig 6 Gender Profile by number of victims and category of incident 2012 & 13



Data Nottinghamshire Police

Time between incident and report to Police

In order to secure forensic evidence for a prosecution it is helpful to report an incident straight away. For this reason Sexual Assault Referral Centres record as "acute" all cases reported within 7 days, and as "historical" all other cases. For the purpose of this Assessment the timescales have been broken down further to show the spread of reporting that takes place. Table 7 below shows that approximately 50% of reported offences took place in the previous month.

Table 7 For Serious Sexual offences, time before offences reported to the Police 2009-13

	2009	2010	2011	2012	2013	Total
7 Days or below	201	143	161	178	182	**865**
8-14 days	28	13	15	18	29	**103**
Less than 1 month	19	27	31	16	25	**118**
1 month to 1 year	98	82	59	81	97	**417**
More than 1 year	120	114	115	137	146	**632**
Total	**466**	**379**	**381**	**430**	**479***	**2,135**

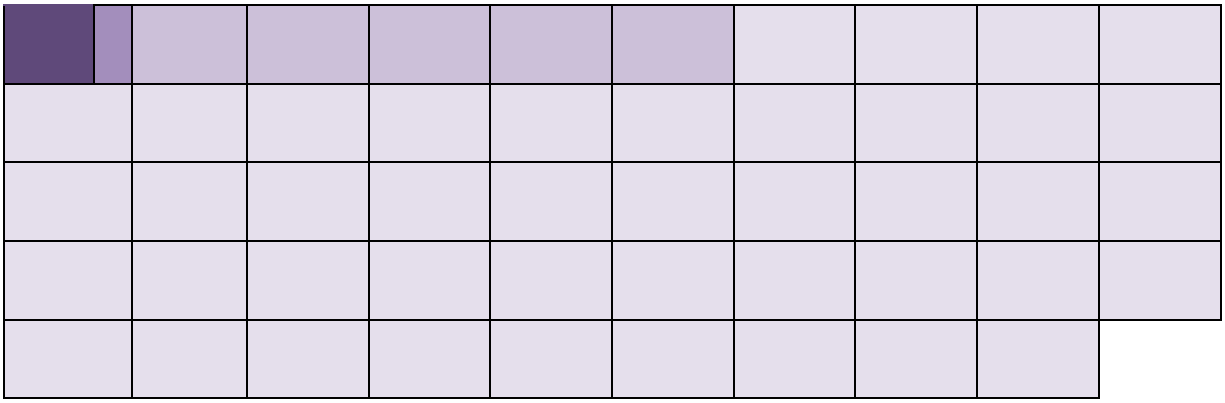
Data Nottinghamshire Police
**slight difference from total in Table 1 is due to Home Office redefinition of offences during 2014*

2.6 Overall Experience of Sexual Assault and Rape

The schematic diagram below (fig 7) attempts to capture the overall experience for victims of sexual offending in Nottinghamshire in 2013. Each square represents approximately 100 people. Therefore, with an incidence of approximately 5894 sexual offences in Nottinghamshire in the past year, of which 613 accessed services (Police or SARC), we know only 103 offenders were charged and 78 were successfully prosecuted

Fig 7 Outcome for Sexual Offences in Nottinghamshire in 2013
Each square represents approximately 100 cases

Estimated number Sexual Offences	5894	
Reports to Police and SARC	613	
Offenders charged	103	
Successful prosecutions	78	



3. Targets and performance

The Table below shows the performance measures in use in Nottinghamshire in 2014

Table 8 Performance Measures

Target / performance owner	**Metric**	**Current Data** **Year 2012-13**
Public Health England	1.12iii) Violent crime - Rate of sexual offences per 1000 population	England 10.6 East Midlands 10.4 Nottinghamshire 9.1
Nottinghamshire Domestic and Sexual Violence Executive	Reduce Serious Sexual Violence Offences Source: Nottinghamshire Police Crime Recording Management System (CRMS)	Serious Sexual Offences reported to the Police in Nottinghamshire have risen steadily: 382 in 2011 430 in 2012 485 in 2013 This is in line with national trends Reasons given for this: • increase in reports of historical abuse “The Saville Effect” • increased confidence in Police and support agencies
Crown Prosecution Service	Successful prosecutions of sexual offences	Nottinghamshire CPS achieving above 80% successful prosecution target

4. Current activity and service provision

4.1 Emergency Provision 24 Hour Services

There is a Nottinghamshire Sexual Assault Referral Centre (SARC) located in North Nottingham and serving the City and County. The Nottinghamshire SARC is called The Topaz Centre and has been developed using the national SARC model. SARCs have been established to increase the effectiveness of criminal proceedings in rape and sexual assault cases by improving the experience of victims and introducing specialist help and support. Nottinghamshire Rape Crisis Centre currently manages the facility under a management agreement with funders. Since April 2013 NHS England has become the responsible commissioner moving from a local partnership involving the Police, City and County Councils and the former Primary Care Trusts. NHS England plans to re-commission SARC services in 2015.

The SARC supports male and female victims from the age of 13. There is a young person's support worker for clients under 18 and these young people will also be referred for safeguarding intervention as required. All individuals reporting rape or sexual assault to Nottinghamshire Police are encouraged to attend the SARC where they can make a full witness statement, undertake a forensic examination, and receive support and guidance from trained staff. From here referrals are made to Genito-Urinary Medicine and other relevant health services. Men and women who choose not to report to the Police immediately can also attend the SARC for the same services and report anonymously. Forensic evidence and witness statements can be stored safely while the individual decides whether or not to report the rape or assault to the Police.

Table 9 By Gender and Number of SARC clients from Nottinghamshire 2013/14

County Referrals	Male	Female	Total
Total	**10**	**155**	**165**

The SARC has two Independent Sexual Violence Advisors (ISVA) whose role is to provide emotional and practical support through the criminal justice system, including attending court and advising on post-trial matters such as compensation claims. (These posts cover the City and County and it has been widely reported that further capacity is needed to meet increased demand) [14]

The SARC is also supported by a Counselling Co-ordinator who is accessible to clients who have acute immediate needs, for up to 8 sessions.

The SARC received 491 referrals in 2013/14. This is an increase from the previous year 2012/2013 of 71 referrals. 165 were County referrals (34%) of all referrals – see table 9 above

[14] Nottingham Rape Crisis Centre Annual Report 2012/13

In 2013/14 the ISVA service supported 333 victims, of these 104 were new clients accepted to the service.

Table 10 Clients supported by ISVAs by assault type 2013/14 City/County

Types of Sexual Assaults	Number	%
Historical rapes and sexual assaults	126	37.83
Recent rapes or sexual assaults	185	55.5
Childhood rapes and sexual assaults	118	35.4
Numbers of clients supported in total	333 *(96 clients experienced more than one type of assault)*	

Table 11 Age profile all SARC referrals City/County

All referrals	**Over 25**	**234**
	18-24	**154**
	16-17	**34**
	13 to 15	**63**
	Unknown	**6**
	Total	**491**

4.2 Domestic and Sexual Violence Helpline

This freephone helpline for women operates 24 hours a day covering Nottingham City and Nottinghamshire. It operates as a gateway for all domestic and sexual abuse services. Victims of rape and sexual assault can phone for confidential advice and support. They will be sign-posted or referred to appropriate services including Police, emergency accommodation, Sexual Assault Referral Centre and Rape Crisis. Helpline staff are fully trained to support survivors and they have use of Language Line for non-English speakers. The Helpline can also be accessed by practitioners who require information about services for their clients

4.3 Support, Counselling and Self Help provision

This is provided by a number of different organisations and further details are shown below.

Each agency measures outcomes in a different way so it is difficult to make direct comparisons.

Mainstream Mental Health Services

Psychological therapies are available through the Let's Talk - Wellbeing Service and Insight. These services provide a range of talking therapies for people experiencing common mental health problems such as depression, anxiety or stress. This may be the first place a sexual abuse survivor is referred to, especially if they have not disclosed the abuse explicitly. Services are provided in local venues across the whole of the County. Referrals can be made to the service via a GP. Self-referrals are also accepted into the service by completing a self-referral leaflet, online referral form or contacting the service by telephone. It is worth noting that Lets Talk Well-being is one of the principle sources of referrals to ISAS specialist sexual abuse service – see page 20 below

Support for those with a Post-Traumatic Stress Disorder (PTSD) is available through the **Centre for Trauma Resilience and Growth** (part of Nottinghamshire Healthcare Trust). This specialist PTSD is service is available through GP referral although resources are limited.

Child and Adolescent Mental Health Service, also run by Nottinghamshire Healthcare Trust will see young people, referred by their GP, with emerging mental health difficulties following child or adolescent sexual abuse. This service has currently undergone a major review and a new structure will be implemented in early 2015 which will see changes in how the services are accessed.

NHS longer term therapeutic services run by Nottinghamshire Healthcare Trust are available for those with a serious mental health diagnosis such as schizophrenia and bi-polar disorder

Nottingham Rape Crisis Centre

Nottingham Rape Crisis Centre is based in Nottingham City and supports female victims of rape and sexual assault aged 13+. All services are provided free of charge. This includes a Counselling line for 18 hours per week offering specialist support and this is the main point of access into the service. It operates Monday-Tuesday 2-8pm, Thursday – Saturday 10am-1pm. Outside of these hours, victims of sexual assault and rape can ring the Women's Aid 24 Hour Helpline or the National Rape Crisis Helpline. They will then be signposted to Rape Crisis, SARC or other suitable local service for on-going help.

Rape Crisis provides face to face counselling:

- Short term: up to 6 weeks
- Medium term: 12-24 weeks
- Long term: 48 weekly sessions

The waiting list for counselling fluctuates between 8 and 17 weeks. The waiting list in March 2014 was 4 weeks for short term support and 12 weeks for long term counselling.

Short term counselling was introduced to provide an interim support solution while victims are waiting to access longer term support, and for those in crisis or more at risk. Regular contact and call backs are provided by volunteers while victims are waiting to access counselling. Rape Crisis also provides training to external agencies; police, schools, NHS.

Whilst this organisation only supports female victims at present, there are plans to develop a male victims' service in the future. At present male victims are signposted to the SARC, or ISAS (see below). Although the service is open to all women across Nottinghamshire, the majority of victims are from the City 60% or South Nottinghamshire 30% as no outreach service is provided. (10% is from out of county).

Services are provided by 7 paid Staff (this includes the 2 ISVAs based in the SARC) and 18 part-time volunteers. Rape Crisis is funded by the City and County Councils, Ministry of Justice (Rape Support Fund and Witness Support Fund) and the City Clinical Commissioning Group.

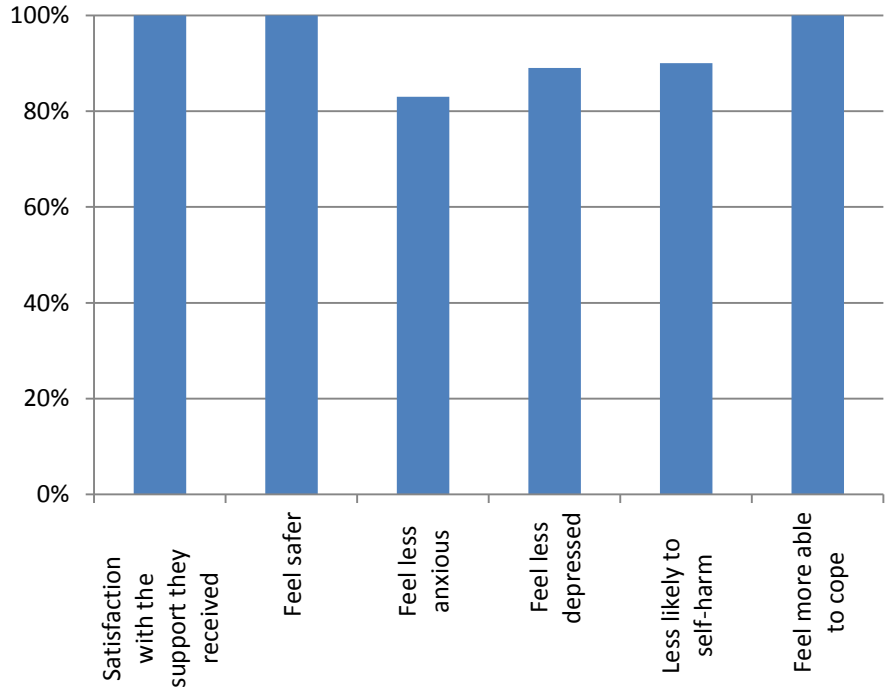
Table 12 Nottingham Rape Crisis Breakdown of Contacts 2013-14

Total number of calls to the Rape Crisis Helpline	3,002 At least 306 County*
Total number of new callers to the Helpline (New call/callers + silent calls)	1,502 At least 182 County*
Total number of individuals registered for the Counselling Service and living in Nottinghamshire County	90
Total number of counselling sessions offered to clients living in Nottinghamshire County	945
Total number of new counselling clients** living in Nottinghamshire County	67
ISVA contacts (linked to SARC) living in Nottinghamshire County	165

**Helpline callers may not disclose address at this stage so this will be below actual figure*

***Primary source of referrals = (1) Self-referrals (2) Referrals from GP/Health professionals*

Fig 8 Post Therapy Outcomes 2013-14 – self reported to Nottingham Rape Crisis



Source Nottingham Rape Crisis centre

Incest and Sexual Abuse Survivors (ISAS)[15]

ISAS provides counselling to male and female victims of abuse. All counselling is provided free of charge. One-to-one and therapeutic group counselling is available. ISAS supported 647 clients in the county in 2012/13.

ISAS also run a 'Rape Support Project' which provides specialist counselling and support for male and female victims over eight sessions. 7 victims are supported by the Rape Project each month and receive 24 hours of support per week. Victims are either supported by telephone, text message or by a counsellor in their local area.

All ISAS counselling is provided by trained, volunteer counsellors. ISAS have 60 volunteer counsellors providing an average of 100 sessions per week.

The majority of ISAS service users are survivors of historical abuse. ISAS have waiting lists, which differ in each area as volunteer counsellors' work geographically. The waiting lists are prioritised according to the level of need and professional judgement at the initial assessment.

Over the financial year of April 2013 to March 2014 ISAS supported 642 clients in the county. 77.57% of clients were women and 22.12% men.

Table 13 : Five most common referral sources to ISAS in 2013-14

Referral Sources	**No.**	**%**
Self-Referral	152	23.68
GP	81	12.62
Let's Talk Well- Being	80	12.46
Drug & Alcohol Services	50	7.79
SARC	29	4.52
Other referral sources include other Mental Health Services and other counselling/support agencies	253	38.93
Total	645	100

Source: ISAS

The improvement in client's health and wellbeing is assessed using the Recovery Star which measures progress on 10 dimensions. The figure below shows the percentage change from first assessment to final assessment. For example: ISAS' clients ability to manage their work situations showed a 100% change over time ie ability doubled over the period of support.

[15] ISAS is an organisational member of the BACP (British Association of Counsellors and Psychotherapy), The Survivors Trust and The National Counselling Society.

ISAS Outcomes in 2013-14 – Percentage change from first assessment:
Managing Mental Health - 133%
Physical Health and Self-Care - 40%
Living Skills - 33%
Social Networks - 75%
Work - 100%
Relationships - 75%
Addictive Behaviour - 33%
Responsibilities - 50%
Identity and Self-Esteem - 200%
Trust and Hope - 250%

SHE – UK (Supporting, Healing, Educating)
Based in Newark, SHE-UK is an organisation originally set-up and run by and for survivors of childhood sexual abuse. It was set up in 1998 in Newark when a gap in self-help provision was identified by ISAS. It supports 400 women over the age of 16. The organisation moved to Mansfield in 2014 and provides the following services in Newark and Sherwood, Bassetlaw and Mansfield:

- One-to-one befriending and mentoring support
- Crisis help in the form of emotional support, advocacy and referrals to specialised agencies
- Drop-in services in Newark, Mansfield, Retford and Worksop on a weekly basis providing opportunities for survivors to meet with other survivors and share their experiences and anxieties
- Information to partners of survivors and also information to male survivors.
- Craft/skills workshops
- Creative Therapy Groups
- Personal Development courses: 12 week courses for a maximum of 8 women working on: assertiveness, confidence building, self-esteem, relationships
- Literacy and numeracy sessions aimed at small groups of 1 - 3 women
- Training courses for: health workers, social workers, mental health professionals and other health professionals.

Future plans include expansion to support male survivors.

4.4 Prevention and Early Identification

Healthy Relationships Education (HRE) and Sexual Abuse Awareness Education
HRE programmes have been devised for 9 -11 year olds and 12 -16 year olds in order to educate children and young people about relationships and personal/private space. The courses concentrate on issues of self-esteem, respect and consent. This directly supports young people's developing awareness of what they can expect in intimate relationships. They cover gender issues and young people learn how gender stereotypes can mislead people about reasonable expectations and their right to refuse unwelcome or dangerous intimacy.

These programmes are offered at reduced cost to schools in high crime areas and are being delivered in 6% of Nottinghamshire schools in 2014. In the academic year 2013-14 these programmes was delivered to 800 Secondary Pupils and 480 Primary Pupils in 20 schools. Evaluation shows high levels of success in changing attitudes in the short term. There is a need for longer studies to assess how well the learning is maintained over time and Equation, the main HRE service provider in Nottinghamshire, is seeking to address this with a local university .

Equation is a local specialist charity. There is potential to integrate this education into an accredited Personal Social and Health Education (PSHE) offer to schools using the specialist sector to create programmes and train teachers or other professionals to deliver in schools. In the past the take up of training opportunities for teachers and school nurses to equip them to deliver these programmes has been poor[16] so further development is required to tailor the programme so it attracts practitioners and gives them the confidence to deliver HRE in schools .

Nottingham Rape Crisis has developed a school-based programme for teenagers to teach about sexual abuse and promote greater safety. It is delivered in South Notts and City secondary schools. Funding is currently available up to March 2015.

This work should be linked to two other initiatives that support young people at risk of harm:

- the cross-authority (Nottingham and Notts) **Child Sexual Exploitation Group** that co-ordinates safeguarding and intelligence about young people at risk on behalf of the Counties two Safeguarding Children's Boards
- the **Young People's Violence Advocates** operating within the local authority and the third sector to identify needs and develop programmes of support for vulnerable young people

Direct Enquiry

Sherwood Forest Hospital Trust Accident and Emergency and Genito-Urinary Medicine Departments have implemented a set of routine questions to patients about sexual and domestic abuse. Nottinghamshire Healthcare Trust assessments include a question about sexual abuse.

This is an area of practice that can be shown to deliver benefits to patients and could be developed in other locations at very little additional cost. Survivors tell us that they want to be asked about sexual abuse and they will not consider disclosure unless they are asked in a sympathetic way. "Routine Enquiry" is used for every single service user, and would be adopted when an agency recognises that sexual abuse cannot be easily identified so may be experienced by any individual attending the service. "Selective Enquiry" is used when individuals present with identified risk factors which give rise to concerns.

[16] Evidence from Equation

This work will benefit from the lessons learnt by the Make Every Contact Count initiative which seeks to maximise the benefit of any presentations to health or community services

"Everyone who comes into contact with members of the public and has the opportunity to have a conversation to improve health"[17]

Workplace policies on Sexual Abuse

This is an area for development in Nottinghamshire where policies to support lone working, prevent sexual harassment and provide information about sources of support for staff, should be included in all places of employment.

This would complement existing policies to support survivors of domestic violence who are working for Nottinghamshire partner agencies

5. Evidence of what works

Interventions and services linked to sexual abuse can be grouped into the following three themes:

- Prevention
- Support services for victims and improving access to justice and health services
- Counselling and Therapy

There is only limited evidence to demonstrate effectiveness in all of these areas but some relevant sources are shown below.

5.1 Prevention

Education in schools has been shown to improve the knowledge of sexual abuse prevention and understanding of risk in school age girls. A UK based study in 2008 of 22 school based sexual abuse prevention programmes concluded that "prevention programmes had a measure of effectiveness in increasing children's awareness, and possibly, skills in relation to child sexual abuse and small average gains in self-protective knowledge"[18]. However the researchers recommended training for teachers alongside the programmes, and consideration to the wider context for the programmes to support disclosures and appropriate safeguarding responses

Sexual Assault Prevention Programmes to educate male students have been reviewed looking at seven studies. The studies showed, through a variety of interventions, a measurable number of formerly held attitudes about rape myth and the role of bystanders in an assaultive situation changed immediately post intervention. One of the studies demonstrated sustained behavioural change but there was limited evidence for this outcome. The review recommended further work on school based education to change harmful attitudes and beliefs that contribute to rape.[19]

[17] http://www.makingeverycontactcount.co.uk/ 11.06.14

[18] Social Care Institute for Excellence. School based child sexual abuse prevention programmes 2008 p47

[19] Journal of Forensic Nursing March 2011 vol//is7 Research Support. US Govt.

5.2 Support Services for Victims and Improving Access to Services

Sexual Assault Referral Centres (SARCs) provide immediate support to victim/survivors of rape and sexual assault to help them to access criminal justice and health provision in a timely fashion. The support workers are called Independent Sexual Assault Advisors (ISVAs). A Home Office study in November 2009 covering 29 sexual violence projects concluded that ISVAs are perceived to add value to existing services by providing non-therapeutic, practical support and information to survivors and by co-ordinating activity with police and courts. The Home office recommended further commissioning but only where ISVAs are professionally trained and part of a local crime and victim strategy with referral routes to avoid duplication, and standardised data collection. This has since been implemented nationally and Nottingham SARC is part of the national and regional network of SARCs.[20]

A comparison between SARCs and Rape Crisis Centres written in 2011 demonstrated positive aspects of each setting and recommended that both are provided in any one area[21]. This is because the study showed that they were likely to attract different victims. The SARC with close affiliation to statutory partners was attractive to those in need of support to navigate the criminal justice system; and the independence of Rape Crisis Centres from statutory partners was seen as a strength for those unwilling to disclose to the police etc.

A comprehensive study of 15 screening programmes for intimate partner violence in health care settings showed that the best results came from a "comprehensive approach" to screening ie one that incorporated a number of screening tools and also provided training to support the screening and where victims were offered immediate access or referral to support services following disclosure. [22]

Mainstream services such as Nottinghamshire Healthcare Trust are engaging in training staff to ask about sexual abuse and in learning how to handle disclosures of sexual abuse. Evidence to support this can be found in a UK study of the Dept. of Health's Victims of Violence and Abuse Prevention Programme. Following this one day training course, 93% of participants were found to feel they have the skills and knowledge to enquire about abuse and respond to disclosure in an appropriate way, and 44% had been asking about abuse in 75-100% of cases.[23]

Direct Enquiry could be introduced into all Accident and Emergency Departments, GUM, Sexual Health, Contraception (especially for emergency contraception) and Lets Talk Well-Being services across Nottinghamshire. Any introduction of Direct Enquiry should be accompanied by staff training to support sexual abuse awareness so that practitioners are equipped to respond sensitively and appropriately to disclosures. Agencies should have realistic expectations for such an initiative. Survivors of Sexual abuse are only going to

[20] Research Report 20 Independent Sexual Violence Advisors – a process evaluation Home office Nov 2009

[21] Different yet complementary - Two approaches.... Criminolgy and Criminal Justice: An international journal Nov 2011

[22] Implementing successful intimate partner screening programmes Social Science and medicine 72 Jan 2011

[23] Uncovering sexual Abuse. Journal of Psychiatric and Mental Health Nursing Feb 2010 vol./is17

disclose when they feel safe. Disclosure is likely to be forthcoming as part of a trusting relationship.

5.3 Counselling and Therapy

We can draw only tentative conclusions from the research about Counselling and Therapy after sexual abuse because of the shortage of recent UK based research in this area of work.

The Nottinghamshire SARC needs assessment in 2011 revealed the following evidence about mental health services following sexual assault:[24]

> *Timely access into Mental Health Services for children and adults is imperative after sexual assault. Westmorland (2003) suggests that therapeutic interventions can prevent the onset of chronic Post-Traumatic Stress Disorder (PTSD) if received soon after the traumatic sexual experience. Further, Foe (1995) found Cognitive Behavioural Therapy (CBT) in the treatment of female victims of sexual assault, as compared to a control group, that those receiving CBT reported less severe symptoms of PTSD at 2 months and 5.5 months after treatment.*

NICE guidance on Post Traumatic Stress Disorder[25] considered evidence from a systematic review of randomised control trials of five therapy groups, including trauma focussed cognitive behavioural therapy, EMDR (Eye Movement Desensitization and Reprocessing) – a form of psychotherapy, stress management, group CBT and other therapies (supportive therapy and non-directive counselling, hypnotherapy and psychodynamic therapies). The review found trauma focussed CBT showed "clinically important benefits" on all measures of PTSD. The studies include participants who had suffered a range of different traumas including accidents, assaults (including sexual assaults in childhood), military combat and domestic violence. Treatment duration ranged from 4 to 18 sessions of between 50 and 120 minutes. There was evidence of benefit of EMDR but this was less persuasive than CBT evidence. There was no evidence to support therapies classed as other. There was limited evidence of effectiveness for stress management therapies and group CBT therapies. NICE guidance recommends PTSD sufferers be offered a course of outpatient trauma focussed psychological treatment of 8 to 12 sessions weekly by the same therapist where the trauma results from a single event.

A review of counselling and psychotherapy services for adult survivors of childhood sexual abuse looking at survivors perspectives and published by Social Care On Line in 2012 covered nine different studies and found that each revealed both positive and negative aspects for survivors. These findings indicated that there is a lack research in this area especially in the UK[26]

[24] Nottinghamshire SARC Needs Assessment Tracey Burton Kristina McCormick October 2010

[25] NICE guidelines [CG26] Published date: March 2005

[26] Counselling and Psychotherapy Research :Adult survivors of childhood sexual abuse perspectives of services: 01/06/2012

6. What is on the horizon?

There are no predictions to indicate any major demographic change affecting sexual abuse going forward. It is thought that the high level of disclosure to Police and specialist support services in 2013 and 2014 is partly attributable to the "Saville Effect", whereby many survivors of historical abuse have come forward following the high profile cases coming to light since the media revealed the crimes of Jimmy Saville and several well-known stars have been charged with historical sexual offences. These increases are continuing in the current year but are unlikely to be sustained in the long term.

Teenagers are a large group in the population already featuring strongly in the sexual offences victim data. Social media and digital technology are widening the opportunities for sexual abuse affecting teenagers and so this is an area of increasing concern.

7. Local Views

7.1 Summary of Victims Feedback (2013)

Service users were consulted on their experiences of accessing and using services across Nottinghamshire. This summary is from a focus group, run with female survivors, another with male survivors and questionnaires from service users of SHE, ISAS, Women's Aid and Victim Support. A total of 43 individuals were involved.

Where did you first talk about your experiences/ who to?

Women first disclosed the abuse to a range of people including:

- GP
- Social Care – Support After Adoption
- Mental health services – as children and adults
- To a friend
- To another family member
- Young People's Services
- Rape Crisis
- A&E
- University counselling service
- Police

They discussed very variable experiences when first seeking help and support. Some were referred effectively to support agencies, others were not believed when they first disclosed.

One woman said that when she disclosed abuse to her GP, they replied with, "stop this incestuous talk."

A young woman who had been adopted as a child found out about her abuse in a letter with a copy of her case file from Support After Adoption. She overdosed and was hospitalised.

"I didn't tell anyone about the abuse for 15 years, but when I did to a youth support service, they were sensitive and referred me to ISAS and SHE."

One woman disclosed to a GP, who prescribed her anti-depressants. No emotional support was provided so she contacted Nottingham Rape Crisis herself, as she was feeling suicidal and didn't know who else to turn to.

What services have you used?

Topaz Centre [SARC]	Nottingham Rape Crisis
ISAS	SHE
Nottinghamshire Women's Aid	Victim Support / Witness Support
Input Mental Health Services	CAMHS
Lets' Talk Wellbeing NHS	University of Nottingham Counselling
Community Mental Health Services	GP Counselling

The male focus group reported that ISAS was the only specialist sexual abuse service they had accessed.

What was your experience of these services?

Feedback of the services provided was very positive, particularly the specialist sexual abuse services. The key phrases used were that the organisations were non-judgemental and provided a safe, supportive environment to share thoughts, feelings and emotions.

Was it easy to access these services?

Most of the feedback received stated that services were easy to contact, but the main issue was the waiting list to access support services. Several victims stated that they had only found out about services years after disclosure and thought that services could be promoted more widely.

Did you experience waiting lists?

Nearly all of the women and men had experienced waiting lists for services for Rape Crisis, ISAS, NHS Counselling and Mental Health Services. Several women reported that they had had to wait 1-2 years for mental health psychotherapy support. Male survivors reported that ISAS had provided access to some support while on the waiting list.

There were serious issues disclosed as a result of waiting lists, with one young woman stating that she seriously self-harmed while waiting for support.

Several women reported that Rape Crisis had kept them informed of their position in the waiting list, which helped to reassure them.

What were the good things about these services?

- Victims reported a supportive atmosphere from people who have had the same experience, with creative therapy.
- Supportive workers who listened without judgement.
- Highly trained professionals, with impressive therapeutic skills.
- Enabled victims to talk honestly and freely.
- Support to help progress with life and to deal with issues.

What things could have been improved?

The following suggestions for how services could have been improved were emphasised:

- Shorter or no waiting lists.
- On-going information on the length of the waiting lists and victims position in it.
- Longer support, which is not time limited.
- More sessions provided by the Topaz Centre, to close the waiting gap for longer term services.
- Longer group counselling sessions for men.
- More trained counsellors for male victims.

One woman stated, "*SHE should be seen as an early help preventative service. Get it right the first time and people will not need as intensive support for other services*."

Experiences of reporting to the police

Several women at the focus group and six questionnaires reported a negative experience of reporting to the police.

- 1 woman reported that she was not believed when she reported, and was accused of lying.
- 2 women said that they were given no support from the police.
- 1 woman said that she was kept waiting for a long time. If she had not been with a support worker she would have left without making a report

Several women reported a lack of sensitivity from police officers and from receptionists at police stations. Several women also reported positive experiences of reporting abuse to the police. They reported them as being helpful and sensitive. For example, a police officer removed his earpiece and switched off his radio to give the victim his full attention.

Experiences of the Court process

They majority of women who had taken their case through the criminal justice system did not attend court. More support and more sensitivity from staff would be welcomed by victims through the court process. Several victims expressed frustration at cases not being taken forward to prosecution by the CPS, and the feeling that they were not believed.

Key Themes from Survivors

A] The impact of sexual abuse All women emphasised the importance of support at the earliest opportunity. The importance of training professionals to recognise the warning signs of sexual abuse, and to ask if they suspect abuse was highlighted. All women said that they would have been able to thrive more if they had been sensitively supported when they first disclosed abuse.

B] Safeguarding Examples of children interviewed with parents present – this prevented disclosure because parent was perpetrator and controlled the professionals successfully. Professionals need to be alert to this issue.

C] Not being believed and provided support Not being believed when victims first disclosed abuse was a recurring theme.

D] Need for flexible support The need for flexible support was emphasised. Need for services and support outside of working hours, to be flexible around people's life demands. Also emphasised was the need for support to not be time limited. Support is often required to assist people through different life events.

E] Support from other victims The majority of service users emphasised the importance of support from other victims of sexual abuse, to know that they are not alone and can be around others with similar experiences.

F] Importance of Sensitivity and Understanding The importance of sensitivity from professionals was repeatedly emphasised by the focus group. Sensitivity by receptionists, asking if people wanted a female professional, giving time and full attention were all emphasised.

G] Abuse as children and adults Several women in the focus group had been abused as children and raped as adults. This illustrates the level of vulnerability of sexual abuse victims and the need for appropriate support.

H] Mental Health Most women had had contact with mental health services as children or adults. There were deep and serious trust issues – one mother said that she only let her son attend childcare provided by SHE, as she does not trust any other agencies or individuals to look after him.

Other Services Victims Would Have Liked – (Service Gaps)

- Outreach and out-of-hours services are important to support people who cannot travel to services and need support around their working day.
- Group therapy for women, for mutual support.
- More self-help therapy. Most helpful to receive support from survivors, as able to talk through issues and abuse when need to, but also just be in a safe welcoming environment.
- For the Nottinghamshire Rape Crisis line to be open longer and each day.
- More services which are not time-limited: to support as and when required.
- More support for male survivors. Victims emphasised that some will prefer to be around women, as many will have been abused by men. Would be good to have groups with women facilitators.
- An awareness raising film by survivors for adult survivors, and for children in schools. Women liked the "Underwear No Pants Rule" recently promoted by NSPCC.
- All of the male focus group reported that training of more counsellors who can support male survivors is a must. Many of the male survivors said that men seemed to be 'forgotten' in many of the services.

Key awareness messages to the public from the survivors

- Promote that keeping secrets is wrong, tell people and seek help – especially message to children that secrets are unhelpful.
- You can thrive after sexual abuse: seek support.
- Recognition of the severity of the impact of abuse and the need for on-going support.
- Needs to stop being a taboo subject and encourage people to talk about it openly.
- Don't focus on the stranger danger message.
- Talk about inter-generational abuse carefully – it can easily stigmatise victims.
- Encouraging more male victims to come forward as a result of sexual abuse becoming less of a taboo subject.

"I attended A&E bloody after being raped. I went to the reception desk and disclosed what had happened. They told that me that I must wait 3-4 hours to be seen. I walked out, went home and did not tell anyone what had happened. I sought no further help."

One woman was abused as a child by her parents. Contracted an STI at the age of 13; GP had no idea what it was and she was sent to a hospital. The consultant invited a group of student doctors to observe the examination with the consent of her parents; never asked her (the child) what she wanted. No questions were asked about sexual abuse; instead doctors asked if she had boyfriends, who she could have caught the STI from. There was no follow up action and STI persisted until she was 17.

Key awareness messages to professionals from the survivors

- Education in schools: need to get the message to schools about sexual abuse.
- Needs to be standard training across healthcare to recognise warning signs and how to ask sensitively – including breast screening, dentists, doctors.

  (1 case of a woman who would not go to breast cancer screening because she had been sexually abused)

- The message that early intervention, recognising the warning signs and selective inquiry at the earliest opportunity will help victims to get better.
- Don't assume that the abuser will always be male.
- You can encourage people to report the abuse to the police, and give forensic evidence anonymously if a recent attack. However, do not force them to report, this is a personal choice.
- For more trained male counsellors to be available.

Thanks for the Services from Survivors

"SHE is a valuable service and a life saver"

"The Topaz Centre and Rape Crisis stopped me from committing suicide and saved my relationships with my husband and son."

"I don't know where I would have been without the support. Life changing."

Male survivors said that the 1 to 1 counselling and group work aimed at men is an excellent approach and had changed their lives.

7.2 Summary of agency and practitioner feedback from the 2014 Nottinghamshire and Nottingham Sexual Abuse Task and Finish Group

This Task and Finish group was established to support the Nottinghamshire Domestic and Sexual Abuse Executive to identify priorities for development in the area of sexual abuse services. The group involved practitioners from NCC Children's Services, Police, Healthcare Trust (mental health and substance misuse services), Equation, ISAS, Rape Crisis and SHE-UK. It looked at prevention, support services, identification and training.

When the group looked at **prevention** there was agreement that much more early education was needed to teach children and young people about healthy relationships and sexual abuse. This was thought to have a preventative function and also a protective one by encouraging disclosures of current or recent abuse of young people.

In relation to **support services** there is recognition that the three local third sector providers (see 4.3) offer vital services to survivors that are not available from

mainstream health provision. NHS patients are referred to these third sector providers by their GPs, and mental health services. There is also recognition that these services have developed independently to cover a range of support services, education and training with overlapping provision and in competition for funding. The suggestion that a single sexual abuse support service would improve efficiency and create a clear referral pathway received a mixed response. Most people supported this in principle but there was also concern expressed about any potential disruption to long term support arrangements and the future for individual provider organisations.

The group discussed methods of improving **identification** of sexual abuse so that appropriate support and therapy can be introduced to address the long term impact of this abuse. The practitioners all agreed that survivors will usually only disclose within a trusting relationship and at a time when s/he is ready to open up. Focus should be on ensuring that staff in all services have the right training and experience to create the conditions for disclosure and make appropriate responses.

Training was seen as key to service improvements. The group welcomed new developments within Nottinghamshire Police to provide new recruits with additional training on sexual abuse by shadowing the specialist sexual abuse team as part of on-going training and development.

What does this tell us?

8. Unmet needs and service gaps

8.1 Unmet needs and service gaps

Disclosure of sexual abuse is low. Just above 1 in 10 victims report to the Police. Others disclose in confidence to specialist support services long after the event. Many tell no-one about their experiences. Services do exist in Nottinghamshire for both men and women, and for teenagers from the age of 13. These services support the current demand with managed waiting lists. The potential demand from undisclosed abuse is estimated at more than twice the current level of demand[27]. Since support services are already stretched with the current level of activity, and dependent upon short term funding arrangements to survive, there is no existing capacity to increase services if demand continues to rise.

There is an absence of carefully planned and properly resourced Direct Enquiry programmes in mainstream services. These need to be supported by specific training on sexual abuse to ensure survivors know they are safe to disclose and are supported following disclosure.

Prevention work with young people is not routinely available in schools or youth projects. Young people at risk are not always identified and supported. (There are links here with the work on sexual exploitation which is led by the Nottinghamshire Safeguarding Children's Board)

There is a local shortage of male specialist sexual abuse counsellors and the is a lack of specialist therapists in mainstream mental health services

8.2 Consequences of not meeting needs of survivors of sexual abuse

The risks of failing to offer services to survivors of sexual abuse are serious (as indicated in 1.2 above)

Increased mental illness in the population

The link between sexual abuse and mental illness is now recognised internationally[28]. A 2010 analysis of 37 studies found:

> "A history of sexual abuse was linked with a lifetime diagnosis of anxiety, depression, eating disorders, PTSD, sleep disorders, and suicide attempts. There was no statistically significant association between a history of sexual abuse and a lifetime diagnosis of schizophrenia or somatoform disorders. Association between sexual abuse and psychiatric disorders persisted regardless of sex of the abuse survivor or age at which abuse occurred. History of rape strengthened the associations between history of abuse and depression, eating disorders, and PTSD. No data were available to assess the outcomes of bipolar or obsessive-compulsive disorder."

[27] See table 4 page 9

[28] Sexual Abuse and Lifetime Diagnosis of Psychiatric Disorders: Systematic Review and Meta-analysis- Mayo Clinic proceedings July2010

Further we know from the Nottinghamshire SARC Needs Assessment[29] that early support and therapy can reduce the onset of serious illness.

Fewer offenders brought to justice

Successful prosecution of offenders relies on confidence to report and the hard work of partner agencies in the investigation of crime, support to witnesses, and effective court proceedings. This work starts with awareness training and successful identification of victims and effective pathways to disclosure.

Higher costs

As detailed by Professor Sir George Alberti [30] and quoted in 1.2 above, there are high costs to the NHS in dealing with the consequences of physical and sexual violence. There are further costs to human lives that arise from agency failure to respond adequately – see service user feedback section 7

9. Knowledge gaps

There are two significant knowledge gaps identified:

9.1 The impact of Healthy Relationship Education (HRE)

Both existing studies and local practitioners have identified the need for longitudinal study (at least 2 years) of HRE. We know that these programmes influence attitudes and behaviour in the short term. Does this learning influence long term behaviour? What are the messages that best resonate with girls to encourage a confident, healthy, safe approach to intimate relationships? What are the messages to boys that encourage a respectful, healthy, safe approach to intimate relationships?

9.2 Benefits of counselling and therapy

Locally the benefits are measured by service providers eg. through the use of the Recovery Star by ISAS (see page 22)

Nationally and internationally there is a need for further analysis of specialist counselling and therapy for survivors of sexual abuse in order to clarify best practice and link to training providers

[29] See 5.3.2 above

[30] *Professor Sir George Alberti - Taskforce report on Responding to Violence Against Women and Children – the role of the NHS (2010)*

What should we do next?

10. Recommendations for consideration by commissioners

In the context of limited finance, the emphasis over the next period will be on improving the provision from mainstream health and criminal justice services to encourage earlier disclosure of sexual abuse and implement appropriate support to support victims. Where possible, Nottingham City and Nottinghamshire County Council will work together to avoid duplication and develop services that meet the needs of local residents.

Recommendations are grouped under four headings:

10.1 Prevention to reduce levels of sexual abuse in the population.

- Promote media campaigns that challenge harmful gender stereotypes and sexualisation of young people. Use the media to encourage greater awareness of risk and publicise the benefits of support services.

- Encourage safeguarding leads in schools to identify young people at risk from sexual exploitation and harmful relationships and signpost them to services that will engage these young people in learning protective behaviour and understanding of risk

- Work with commissioners of children's services to ensure Healthy Relationships Education is included in the "Mainstream Offer" to all schools.

- Support the research proposal for a longitudinal study of Healthy Relationships Education for young people to test whether knowledge, understanding and attitude change are sustained over several years.

10.2 Improved awareness and identification of sexual abuse by mainstream services

- Ensure criminal justice, mental health and primary care service providers are aware of sexual abuse and how to respond and signpost appropriately.

- Clarify and support the implementation of routine and selective enquiry about sexual abuse in identified mainstream services to increase identification and disclosure. . (Recognising that prior training is essential for successful implementation)

- Analyse existing information from specialist services, Health and Police into a quarterly data report on sexual abuse

- Include sexual abuse as an element in the Human Resource support programmes of partner agencies. Eg The Workplace Health Scheme being developed by Nottinghamshire County Council

10.3 Support and access to services for survivors of recent or current sexual abuse and for survivors of historical sexual abuse

- Promote the support services in Nottinghamshire through the widespread use of the 24 Hour Freephone Domestic and Sexual Violence Helpline information cards available free to all agencies, and targeting mainstream NHS services that survivors already access.

- Work with mental health commissioners to address waiting times for access to psychological therapies and the availability of specialist counselling services. Developments to include a consistent approach to measuring outcomes for counselling services.

- Work with the Nottinghamshire Police and Crime Commissioner and NHS England to ensure that Nottinghamshire SARC is commissioned successfully with adequate staffing

- Ensure services can safely meet the needs of both male and female survivors of sexual abuse

10.4 Criminal Justice

- It should be recognised that effective investigation and prosecution of sexual assault and rape are key to building the confidence victims need to disclose sexual abuse.

- The criminal justice agencies have a number of plans in place to improve their procedures. These should be linked with the work of other partners using the existing Safer Nottinghamshire Board and Health and Well-Being Board structures

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Appendix A: Sexual violence definitions in the law

The Sexual Offences Act 2003 came into force in May 2004.

4 offences are non-consensual offences in that they all require proof of an absence of consent on the part of the victim; each carries the potential of a maximum life sentence.

For the purpose of these and other offences in the 2003 Act consent is defined for the first time as

"*…a person consents if he agrees by choice, and has the freedom and capacity to make that choice.*"

The word "consent" in the context of the offence of rape is now defined in the Sexual Offences Act 2003. A person consents if he or she agrees by choice, and has the freedom and capacity to make that choice. The essence of this definition is the agreement by choice. The law does not require the victim to have resisted physically.

Rape now includes non-consensual vaginal, anal and oral sex; involving penetration with a penis. While only a man can commit the act of rape both men and women can be victims of rape. Other acts include assault by non-penile penetration, sexual assault and causing a person to engage in sexual activity without consent

Penetration, touching or any other activity is sexual if a reasonable person would consider it sexual because of its *nature*.

The 2003 Act also includes a set of situations where it will be harder for the defendant to argue that his victim consented.

These are called "presumptions" in law. There are two kinds of presumptions within the Act. The "conclusive presumptions" make it impossible to use a consent defence and therefore much more likely that a defendant will be found guilty. These cover situations as when the assailant intentionally deceives the victim into thinking his actions have another purpose, such as a medical examination or pretends to be someone you know.

The "rebuttable presumptions" simply mean that the defendant has to produce more evidence if he wants to argue that there was consent.