# Sexual Violence and Abuse: A Thurrock Joint Strategic Needs Assessment

October 2019


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# Acknowledgements


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This needs assessment features information collected from a large number of local victims/survivors (83 responses to the survey and 6 victims/survivors who were interviewed and videoed, and 10 young people who planned and delivered the South Essex Rape and Incest Crisis Centre (SERICC) REAL Conference in April 2019). Our thanks go to you, to SERICC, Healthwatch and Quest Music Services for helping us to truly tell your stories and use it to influence our findings.

Our thanks also go the 128 professionals who completed the survey and those who supplied commentaries and data in order to inform our understanding of sexual violence and abuse in Thurrock.


### Notes to the reader

In this document, sexual assault, sexual violence, sexual offence and sexual abuse are used interchangeably and are not necessarily in their technical or legal definitions. The term victim/survivor is used to refer to those subjected to sexual violence and/or abuse and encompasses ‘victim’, ‘patient’, ‘complainant’, ‘client’ and ‘survivor’. Where reference is made to a time since a victim/survivors incident of sexual violence or abuse, the terms ‘recent’ and ‘non-recent’ are used interchangeably with ‘historic’ and ‘non-historic’.

Within this document, reference is also made to the names of specific organisations who provide a range of specialist and non-specialist sexual violence and abuse services in Thurrock. It is to be noted that although these were correct at the time of publication, they are subject to change based on commissioning outcomes.

Where videos have been embedded, please right click on the film icon and select ‘*open hyperlink’*. You will be directed to a YouTube page and will need to press play.

# Executive Summary

Tragically, sexual violence and abuse (SVA) is a widespread problem that is still very much prevalent in our society. These crimes are serious and can have devastating and long-lasting effects on victims/survivors including a range of physical, emotional and psychological impacts. The experience of sexual violence and abuse at any age and whether male or female can have significant effects on every aspect of a person's being and life; on their mind, body, behaviour, thoughts and feelings. It is also recognised that sexual violence and abuse affects not just the victim/survivor, but the offender and the families and communities around both of them.

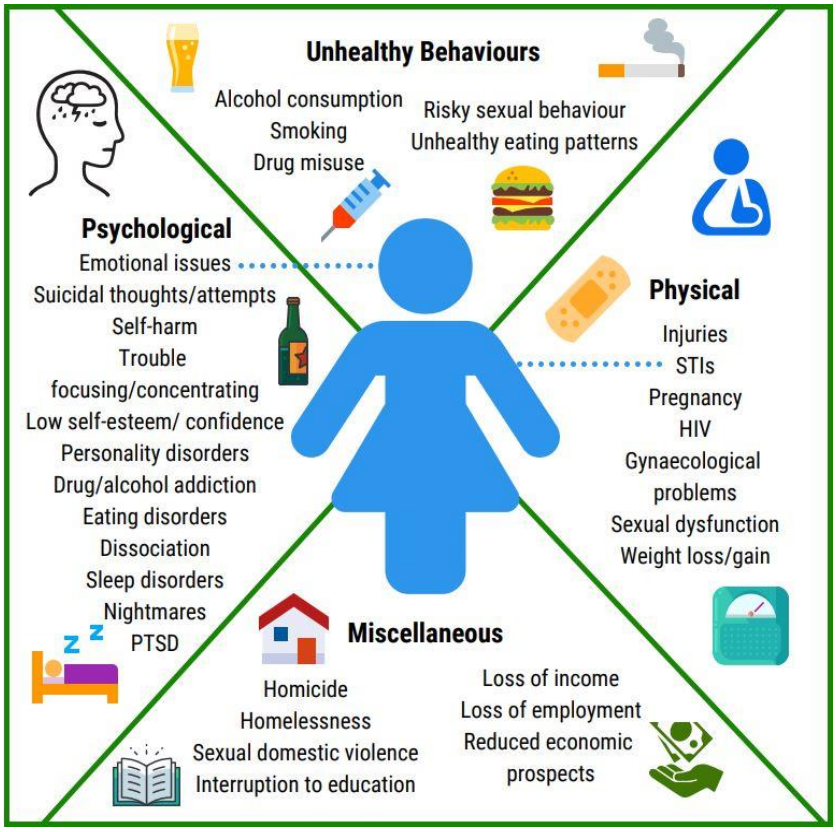
This needs assessment sought to further our understanding of the nature, prevalence and types of sexual violence and abuse occurring locally. This understanding will enable us to ensure that efforts are made to prevent these horrific crimes happening in the first place and ensure survivors are appropriately supported to cope and recover from the aftermath of their experience through the provision of suitable and high quality support when they need it. A number of key stakeholders were involved in the development of this needs assessment including professionals from a range of organisations including health, social care, criminal justice, specialist sexual violence and abuse services and most importantly, local victims/survivors. Findings from this needs assessment involved the analysis of literature, data from the Police and Social Care, specialist and non-specialist sexual violence and abuse services, referral data and engagement with local professional and victims/survivors.

It is widely accepted that there are difficulties establishing the true prevalence of sexual violence and abuse, predominately due to survivors not wishing to report or disclose their experience to formal sources. **Only 17% of victims/survivors of sexual violence and abuse report their experience to the Police.** Whilst some victims/survivors chose to disclose their experience to a friend, relative, colleague or professional, **it is estimated that 31% of victims/survivors do not tell anybody**. This is particularly evident in cases of child sexual abuse, with the **average time taken to disclose suggested to be 26 years**. National estimates from the Crime Survey for England and Wales suggest that 20% of females and 4% of males aged 16-59 have experienced sexual assault since the age of 16. Locally this is equivalent to 10,116 females and 1,985 males**. It has been estimated that locally approximately 2,718 Thurrock residents of all ages, experienced some form of sexual violence or abuse in the last 12 months.**

Respect for the preferences of survivors should be the golden thread that runs through any local provision of support for victims/survivors of sexual violence and abuse. For this reason, extensive engagement work was conducted via surveys and in-depth interviews with local victims/survivors and has formed a fundamental part of our understanding of survivor's experiences. Local survivors spoke bravely of the multitude of impacts that have resulted as a consequence of their assault or abuse, as well as their expectations and experiences of disclosure and accessing local services.

In order for victims/survivors to cope and recover from the experience of sexual violence and abuse, it is imperative that they have timely access to effective services that support them in a manner that is suitable to their needs and preferences. Due to

the wide-ranging impacts that SVA may have on victim's/survivors, it is recognised that survivors may require a number of services, often from a range of providers, examples of which may include counselling, advocacy, drug and alcohol, sexual health and support with housing, financial and criminal justice needs. Some of the impacts are summarised below:




The effects of sexual violence and abuse also incur vast socioeconomic costs which manifest as both tangible and intangible costs as well as direct and indirect costs. The tangible costs of SVA are taken to include direct costs such as; medical, physical and mental health costs as well those related to housing, police investigations and criminal prosecutions. Indirect costs may also occur through employee's loss of productivity and income and personal financial losses due to injury or inability to work. Intangible costs are taken to include the psychological pain and suffering of victims/survivors, and a generalised, heightened fear of victimisation which may impact on ability to function normally and achieve aspirations. It is important to recognise that these costs can stretch on for years and decades following an incident of SVA. Providing survivors with prompt access to services that support them to recover in the immediate aftermath and beyond is not only ethical but also likely to be highly cost effective.

Through the provision of appropriate and early intervention it is likely that we are able to prevent, if not mitigate, some of the complex, long-term health and mental health problems amongst victims/survivors, in turn reducing the long-term costs and consequences for victims/survivors and their communities.

Locally a number of services are in place to support victims/survivors, with the offer including both specialist and non-specialist sexual violence and abuse services. Whilst some services are specifically commissioned to work with victims/survivors, with specialist provision including the Sexual Assault Referral Centre (SARC) at Brentwood Hospital and specialist sexual violence and abuse counselling services including counselling, advocacy and Independent Sexual Violence Advisor (ISVA) service delivered by SERICC, others provide a more generic offer e.g. sexual health, drug and alcohol and mental health services. The responsibilities for commissioning these services sit with a number of organisations from a range of sectors. The above presents a number of difficulties in the local provider landscape and requires a number of organisations and commissioners to work together in order to ensure effective approaches are in place to support victims/survivors of SVA.

## We know that not all survivors are known to local services.

In 2018, **316 victims of reported sexual offences were recorded in Thurrock**. This has increased from the previous year at a faster rate than the corresponding population growth. The majority of these victims:

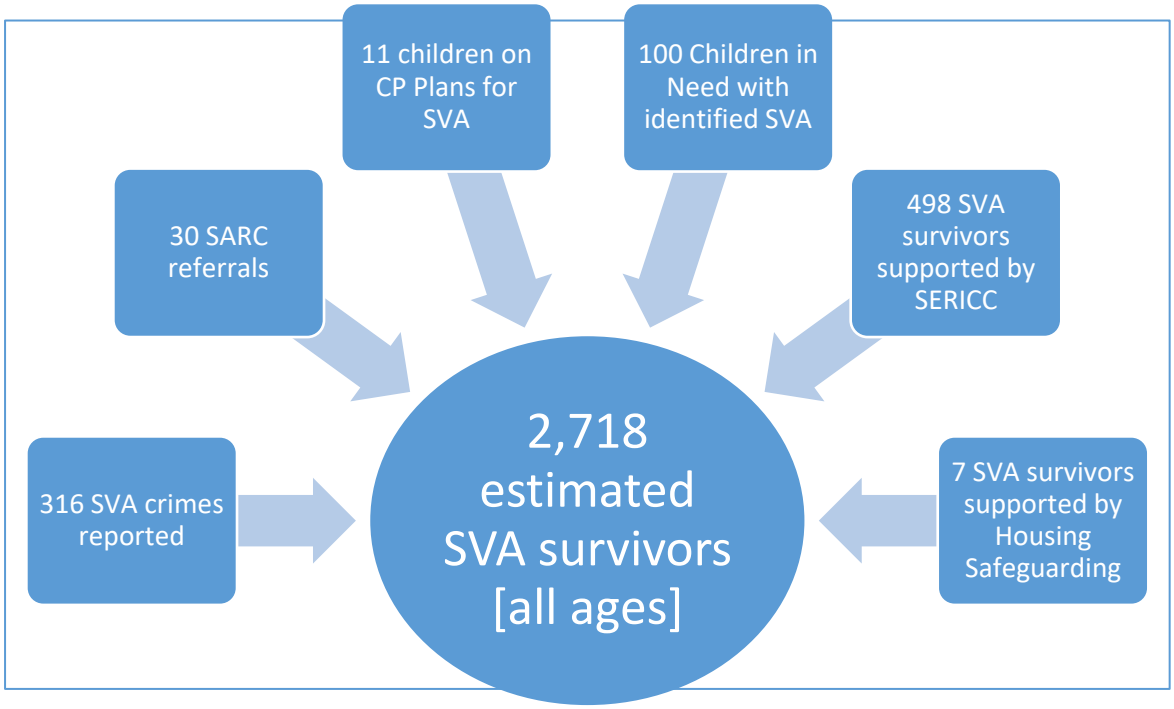
- **Young (over half were aged < 17 years)**
- **Female (over three quarters were female)**

The vast majority (91%) of suspected perpetrators were male, a higher proportion than seen in national data from the Crime Survey for England and Wales which shows a male perpetration proportion of 74-79% for sexual offences. Locally, suspected perpetrators tended to be younger men, with peaks occurring in the 18-34 age range (42%). However a quarter of suspected perpetrators were aged < 17 years, potentially signalling some 'peer on peer' activity; although given their age, they may be subject to increased safeguarding measures and therefore more likely to disclose or seek help following experience(s) of SVA.

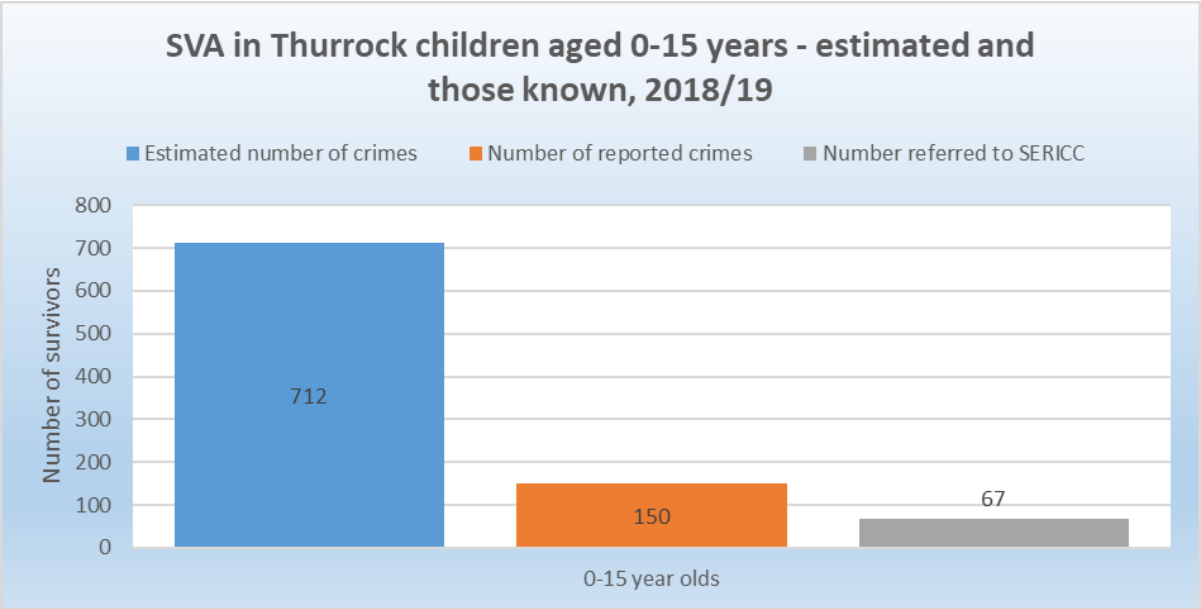
Sexual violence and abuse can occur in a number of different contexts. Crimes related to SVA often represent an exertion of power from the perpetrator over the survivor and may be used as forms as a form punishment, blackmail and to instil fear within a victim. Victims may also by sexually abused or exploited through forms of criminal activity including human trafficking, modern day slavery, forced work within brothels and grooming, often for the financial gain of somebody other than the victim. Anecdotal intelligence from local stakeholders suggests that Thurrock may have specific issues and crimes occurring that relate to SVA however at present we do not have robust evidence to enable us to understand the full extent of any overlaps that may occur. Due to an absence of crime related data, the only link we are able to establish is that of Domestic Violence (DV) and SVA, with 18% of the Thurrock sexual offences reported to Essex Police in 2018 specifically linked to DV. The presence of gangs and organised criminals targeting and exploiting of people cannot be underestimated and is currently one of Essex Police's biggest challenges.

The number of Thurrock residents accessing the local Rape Crisis Centre provided by the South Essex Rape and Incest Crisis Centre (SERICC) for a range of services related specialist sexual violence and abuse counselling and advocacy services has **increased** by 20% between 2015/16 and 2018/19, with **498 residents accessing in 2018/19**. This is still much lower than the 2,718 victims/survivors who are estimated

to have experienced SVA in the last 12 months. The below summarises the known presentations of SVA survivors.




Whilst under-reporting and subsequent service presentation is present across all age groups, children and young people reporting SVA may still not be receiving specialist support, even amid the tighter safeguarding protocols in place around them. The chart below shows that of the 712 children likely to have experienced SVA, approximately 21% of them were reported to Essex Police and SERICC received referrals for only **9.5%** of these estimated victims/survivors.



## User Voice

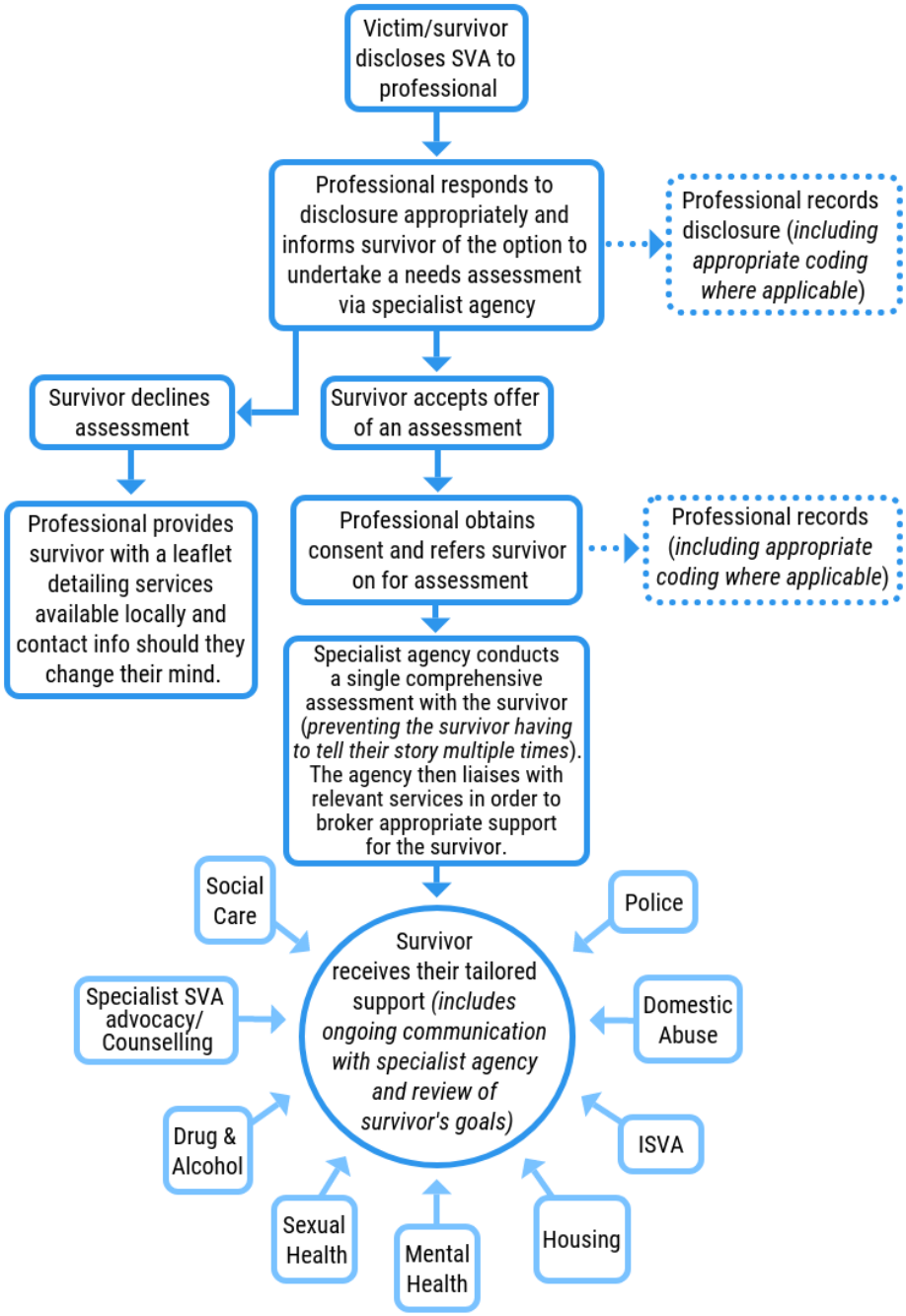
Local victims/survivors spoke of the experiences of fragmented pathways, poorly handled disclosures, difficulties navigating the landscape of numerous providers and to their frustration, often having to repeat their traumatic experiences to multiple members of staff across various services. victims/survivors frequently mentioned the poor responses they were often met with following disclosure or attempts to seek help or support. This left victims/survivors feeling a range of emotions including shame, guilt and embarrassment, commonly reported as being just as traumatic as the abuse itself. It is important to recognise that the majority of victims/survivor who participated in the engagement had accessed specialist sexual violence and abuse support from SERICC, and therefore this needs assessment lacks an understanding of the thoughts and experiences of local victims/survivors who may not have not accessed services, whether specialist or non-specialist. Although local professionals generally had a good level of understanding of local services available to support victims/survivors, they had varying views regarding how well services worked together to support victims/survivors and many professionals requested further training to help them handle disclosures appropriately. This must be addressed within future work.

Whilst this needs assessment considers the current population in Thurrock, it is imperative that future work considers the projected population increase of 20.04% by the year 2041 and changes in migration patterns. Thurrock has a number of assets in place that will help drive forward the approach to sexual violence and abuse. As a unitary authority, Thurrock benefits from one single Clinical Commissioning Group, one Health and Wellbeing Board and one Healthwatch, providing a geographical foot print for planning, delivery and integration of healthcare, social care, public health and other local authority services. The Essex Sexual Abuse Strategic Partnership in collaboration with key partners is also pioneering innovative ways of working including the development of **Project Goldcrest.** This project allows victims of sexual violence who do not currently wish to participate in the prosecution of their perpetrator to anonymously store forensic evidence at the Essex SARC should they wish to proceed with a criminal justice process at a later date. In the meantime Essex Police are able use this evidence anonymously to disrupt and prosecute perpetrators.

## A new integrated model of care for victims/survivors.

The most significant recommendation of this needs assessment is the proposal to develop a **new pathway of support** (see Chapter 11) for local victims/survivors of sexual violence and abuse. The implementation of this pathway will ensure a radical transformation in the way survivors are offered support to help them cope and recover from their experience. Too often, we heard examples of agencies involved in SVA not working effectively together, of survivors having to tell their story multiple times, and of having to access a myriad of different agencies to obtain the support they required. This pathway recognises that SVA may have a number of wide ranging impacts on a survivor and therefore a number of organisations may be involved in providing support to survivors, regardless of whether they are a specialist sexual violence and abuse service or not. Examples of services to be included within the pathway include; specialist sexual violence and abuse advocacy and counselling services, Independent Sexual Violence Advisors, community mental health services, drug and alcohol services, sexual health services and housing.

Our ambition is for every survivor who makes a disclosure of sexual violence and abuse to be offered a comprehensive assessment to identify any appropriate support to help address their needs. Should the survivor agree and provide consent, the professional they disclose to will refer them to a specialist agency in order to undertake an assessment once which will assess which service(s) are appropriate. Following this assessment, the specialist agency will liaise with the appropriate support services in order to provide the survivor with a tailored package of support. The survivor will then be able to access their support. This coordinated offer of support will drive collaboration between all relevant agencies and in turn, facilitate better access in to services for survivors whilst reducing the number of times they are required to tell their story to professionals. This pathway is demonstrated below and explained in detail in Chapter 11.



## Key issues and recommendations.

The key issues and recommendations are set out in the table overleaf.

We recommend that locally a Sexual Violence and Abuse Stakeholder Partnership is established in order to take forward the recommendations from this needs assessment and ensure an ongoing and consistent focus on SVA is present in Thurrock. These recommendations will only be successful if sexual violence and abuse is viewed as everybody's responsibility and key stakeholders work in partnership.

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations around improving data** | | |
| Locally there are low levels of reporting of SVA crimes to the Police. Although this is observed nationally, the Thurrock rates are lower than comparable authorities (see chapter 7 for further information) | The Essex Sexual Abuse Strategic Partnership should commission dedicated SVA campaign work s in order to increase public confidence in reporting crimes, which in turn should reinforce positive outcome messaging. | Essex Sexual Abuse Strategic Partnership (working with Essex Police and Crown Prosecution Service) |
| Data collection mechanisms are not currently set up to enable identification of the number of survivors accessing all agencies in Thurrock | Non-specialist SVA organisations (e.g. sexual health, mental health, drug and alcohol services) should embed questions related to SVA in to their relevant templates/assessments in order to improve identification of SVA survivors. | All relevant non-specialist SVA organisations, to be determined and overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| The systems/ databases/ datasets used by some organisations locally are not appropriately set up to record SVA related information. | Relevant agencies including General Practice, hospitals, sexual health, mental health provider NHS trusts, drug and alcohol treatment services, domestic abuse services should develop a single, consistent recording protocol in order to facilitate disclosures and identify SVA survivors. This protocol should include:<br>- the use of mandatory questions<br>- appropriate datasets<br>- appropriate coding/categories<br>- minimising opportunities for SVA to be lost within free text sections of case notes.<br>For health settings, this may be most effective at a Mid & South Essex STP (Sustainability and Transformation Partnership) approach considering the shared resources i.e. hospitals, Police force, Single Point of Access for Rape Crisis Centres). | To be overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership with support from relevant organisations |
| Due to inconsistent data capturing across organisations, it is difficult to identify victims/survivors use of services and their pathways between services (e.g. at what point they access support, type and frequency of support received, the duration support was received for) | Thurrock SVA Stakeholder Partnership should undertake baseline mapping activity to identify current data recording practices within each agency around service usage in order to make adaptations to reporting requirements and data collection. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
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| **Recommendations around the prevention of SVA** | | |
| Local approaches to prevention of SVA are predominately school-based | Thurrock SVA Stakeholder Partnership should identify other options and channels to communicate prevention messages regarding so that a population based approach can be achieved. Messages should also be adapted to particular population groups where appropriate (e.g. those at high risk of SVA). | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| Existing school based prevention activity is inconsistent and often focuses only on particular year groups. There are opportunities to strengthen school-based approaches to prevention activities. | Schools, Academies and Thurrock Council's Education and Skills Department should capitalise on the opportunities presented by the Department of Education's mandatory requirement for the delivery of Relationships Education in Primary Schools and Relationships and Sex Education in Secondary Schools from September 2020 to ensure that knowledge of SVA and services available to support survivors is embedded and consistently covered within the curriculum. | Thurrock Council's Education Department, Head teachers, PSHE Leads, Safeguarding Leads etc. |
| | Proactive messaging on SVA and key topics such as consent, grooming and CSE should be consistently delivered to all age groups and embedded into each school's wider pastoral offer. | Thurrock Council's Education and Skills Department, Head teachers, PSHE Leads, Safeguarding Leads etc. |
| **Recommendations on addressing harmful behaviour of perpetrators** | | |
| Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34). However, locally there is an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours | *See recommendations above regarding approaches to the prevention of SVA (5.4)* | |
| | Thurrock's LSCP should develop a training proposal to ensure the wider children and young person's workforce (e.g. social workers, teachers, youth workers, School Wellbeing Service) are trained and appropriately supported to identify and screen for concerns linked to harmful sexual behaviours and/or sexual violence and abuse. | Thurrock Local Safeguarding Children Partnership (LSCP) |
| | Thurrock's LSCP should specifically include actions to address the issue of young suspected perpetrators within their relevant policies and action plans. | Thurrock Local Safeguarding Children Partnership (LSCP) |
| | Thurrock Sexual SVA Stakeholder Partnership should review and assess the appropriateness of existing provision designed for young people who are displaying harmful sexual behaviours to ensure an effective offer is in place locally. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | Thurrock's LSCP and NHS Thurrock Clinical Commissioning Group should ensure the Guidance from the National Institute for Health and Care Excellence (NICE) regarding harmful sexual behaviour among children and young people (NG55) is adopted and successfully implemented locally. | Thurrock Local Safeguarding Children Partnership (LSCP) |
| | Thurrock SVA Stakeholder Partnership should review the findings of the Learning and Development Group of Southend's Safeguarding Children's Board who have recently reviewed Harmful Sexual Behaviours in order to knowledge and best practice county- wide and implement changes locally where appropriate. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
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| Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remits mentioned above | Thurrock SVA Stakeholder Partnership should conduct a review of the evidence base of relevant programmes and potential demand locally in order to identify a suitable programme. Funding is to be secured if applicable. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| Local Police data shows that 11% of suspected perpetrators (of SVA offences reported by Thurrock residents) were reported for committing more than one offence. We are currently unaware of how this compares to other areas/nationally | The Essex Sexual Abuse Strategic Partnership should conduct a review of the offer of programmes to those who have been convicted of sexual violence and abuse crimes and create a sustainable behaviour change programme for perpetrators of SVA (to be informed by the Essex Sexual Abuse Strategic Partnership's Sexual Violence Strategy, due to be published late 2019). | Essex Sexual Abuse Strategic Partnership |
| Local and national data and engagement with survivors shows that both children and adults experienced SVA in a domestic setting or had a close relationship to the perpetrator (e.g. partner, ex-partner family member) | Embed knowledge related to recognising SVA in domestic settings amongst front line professionals to increase confidence in recognising and reporting incidences of SVA. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| **Recommendations for improving responses to disclosure** | | |
| Locally, survivors report a lack willingness to disclose their experience of SVA to anybody (including formal and informal sources). A number of factors are known to deter disclosures and willingness to seek support. Local engagement tells us that these factors include lack of confidence to access services, fear of not being believed and a low perpetrator conviction rate | The Thurrock SVA Stakeholder Partnership should implement a coordinated programme of communications activities to be delivered to the public, to include; reducing the stigma of SVA, tackling social myths and stereotypes in order to increase public confidence in reporting crimes and seeking appropriate support | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
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| Locally, disclosures are more commonly being made to informal sources (i.e. family and friends) rather than to professionals. This may result in disclosures not being handled appropriately and/or survivors not being aware of the relevant services and support available | Thurrock SVA Stakeholder Partnership should review suitable training programmes (whether existing or bespoke) that can be delivered in order to support informal sources respond appropriately to disclosures. Examples may include the Thurrock Community Safety Partnership's (CSP) Challenging Myths Changing Attitudes training, or a variant of the J9 Domestic Abuse Awareness training tailored towards SVA. These should be delivered consistently across Thurrock, including to families/friends where requested. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| Locally, not all responses to disclosure, whether to formal or informal sources, have been handled appropriately and sensitively, which can be extremely traumatic to the survivor.<br><br>Survivors often reported that professionals in a rush to follow organisational protocol and 'cover their own back' disclosed information to multiple additional professionals leaving the survivor feeling that 'they had lost control of the process' | Thurrock Council's Education and Skills Department in partnership with local schools and Academies should audit all school policies on SVA disclosure to ensure a consistent approach based on best practice that keeps the needs of the survivor at the centre of the process | Thurrock Council Education and Skills Department<br><br>Head Teachers and Academy Chief Executives |
| | Thurrock SVA Stakeholder Partnership should commission a coordinated programme of training/communications activities to be delivered to professionals and informal sources, to include; reducing the stigma of SVA, tackling social myths and stereotypes, in order to improve responses to disclosure. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| | Thurrock SVA Stakeholder Partnership should develop a bespoke toolkit for professional use in order to facilitate appropriate responses to disclosure. This toolkit should be issued to all appropriate frontline professionals in Thurrock. The toolkit should be used to supplement training and provide information including safeguarding requirements, appropriate language, local service provision and referral pathways. | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| Some professionals surveyed said that they did not feel confident dealing with disclosures, with many professionals requesting further training in this area | Thurrock SVA Stakeholder Partnership should conduct a full evaluation of training possibilities, seeking input from staff/management within key organisations, in order to determine which are most effective in increasing professionals' confidence responding to disclosures. This training should be then made available to professionals in order to ensure they are appropriately informed, skilled and confident in handling disclosures. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
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| | A toolkit to be developed and issued to all frontline professionals in Thurrock in order to improve ongoing confidence during and following disclosure and ensure survivors are informed of options for support.<br>This toolkit should:<br>- Include information regarding conducting risk/needs assessments for survivors, as per relevant safeguarding processes<br>- Contain information including operational protocols, safeguarding policies, practical skills and information regarding service provision and referral pathways<br>- Provide professionals with a clear understanding of how to respond appropriately to disclosures, including the actions that should follow<br>- Incorporate the findings of this needs assessment and the Thurrock REAL. Conference<br>- Seek input from specialist SVA services<br>- Be coordinated by the new Thurrock SVA Stakeholder Partnership to oversee the development and support implementation (see recommendation in chapter 11). | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| Some survivors reported that their disclosures/information related to their SVA was shared with more people than they felt was necessary | The toolkit and training as mentioned above should address this issue through providing professionals with a clear understanding of the processes following disclosure including what information should be shared and with who. | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| Following disclosure, 68% of local survivors relied on professionals giving them further information/ signposting towards seeking specialist help themselves rather than a referral being made on their behalf. Whilst SERICC appear to be well-known in the borough, the process would be smoother and may result in better outcomes if survivors were referred directly using appropriate mechanisms | Referral pathways and processes into specialist SVA services must be developed, agreed with key stakeholders and used by all referring organisations. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| | Organisations to network more effectively so that they better understand each others' service offer for survivors, and to be directed to make referrals in to specialist support services as opposed to signposting.<br><br>Thurrock Public Health Service to organise a conference for all local stakeholders to launch this Joint Strategic Needs Assessment product and commence discussion between stakeholders. | All providers of services that may support SVA survivors, to be identified and facilitated by the Thurrock Sexual Violence and Abuse Stakeholder Partnership<br><br>Thurrock Council Public Health Service |
| | Where practicable, referral forms to SVA support services should be automated or embedded into organisational information systems (e.g. the Systm One or EMIS systems in General Practice and hospital systems) | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
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| **Recommendations for those in the reporting of crimes to the Police** | | |
| Thurrock has lower levels of reporting SVA offences to the Police than other similar areas, and of those that are reported, there is a very low proportion that lead to the suspect being charged. There is variation by age group in terms of the proportion of women estimated to have experienced SVA who have reported it to the Police, particularly seen in women aged 25-44 years (the rate is between 6-8%) | The Essex Sexual Abuse Strategic Partnership should ensure that Project Goldcrest is evaluated in order to determine whether it is effective in encouraging survivors to participate in forensic evidence gathering and supporting the Police with prosecuting perpetrators. | Essex Sexual Abuse Strategic Partnership |
| | Communications activity as previously recommended should seek to target women in this age group to increase confidence in reporting. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| **Recommendations for improving access to services** | | |
| Survivors reported difficulties accessing the right service(s) at the right time. The extent to which barriers to accessing support occur locally remain largely unknown. Within our engagement work with survivors who had accessed services barriers to support were seldom mentioned, however the Needs Assessment lacked input from local survivors who were not known to have accessed support. | As part of the implementation of the new pathway of support (see chapter 11) a full communication programme to be effectively implemented to all relevant front line services. This will ensure survivors are able to access the right services at the right time. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | A communications plan to inform the public of the new pathway should be developed. The plan should be informed by survivor's preferences for receiving information in order to increase knowledge and confidence in accessing services. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | Engagement work should be conducted with local survivors who have not accessed support in order to better understand local barriers. | Providers and Commissioners of specialist SVA services |
| **Recommendations for improvements to existing service provision** | | |
| Engagement with survivors recognises that they value a holistic offer of support and there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is | Providers and commissioners of specialist SVA services should agree a new integrated model and care pathway of support and then jointly commission/deliver it. The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services.<br><br>The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop). | Providers and Commissioners of specialist SVA services including Adult and Children's Social Care Commissioners, Mental Health Commissioners at NHS Thurrock Clinical Commissioning Group |

| Issue Identified | Recommendation to address this | Responsibility |
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| perhaps needed to reduce these inconsistencies | | |
| Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways, waiting times, quality. | Local survivors should be invited to co-produce the new pathway of support and their views are used to develop services and form part of quality assurance of commissioned services. | Providers and Commissioners of specialist SVA services |
| Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes. It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres), there may be benefit in commissioning more SVA services at a county-wide level. However, it is to be noted that this needs assessment was solely focussed on Thurrock and therefore further work is required in order to ensure an appropriate offer is provided across Essex. | Adult and Children's Services Commissioners in Thurrock Council and NHS Thurrock CCG should review existing mechanisms for recording performance outcomes within specialist SVA services with the ambition to agree a consistent approach to monitor SVA outcomes within local contracts. | NHS, Council and Criminal Justice commissioners of specialist SVA services |
| | Council and NHS commissioners should integrate commissioning of SVA services and seek to develop a single contract, shared budget, single outcomes framework and collaboratively commission specialist SVA services across Essex. | NHS and Council Commissioners of specialist SVA services |
| | Specialist SVA services should be commissioned based on the evidence base presented within this Needs Assessment and accounting for data which will be collected through the proposed recommendations. | NHS, Council and criminal justice commissioners of specialist SVA services |
| Local engagement with survivors identified that over 50% said they waited for less than one month before receiving support, however, some survivors reported finding it hard to be on a waiting list once they made the decision to access support | An offer of emotional and practical support must be made available to all survivors on the waiting list for specialist SVA services. This could be informed by the evaluation of the locally delivered Synergy Essex '*First Responder Project'.* | NHS, Council and Criminal Justice commissioners of specialist SVA services |

| Issue Identified | Recommendation to address this | Responsibility |
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| | | |
| **Recommendations around improving strategic oversight for SVA** | | |
| There are already a large number of existing strategic groups, networks and leadership opportunities to champion this agenda, however it is not quite clear where the lead responsibility sits locally | Form a dedicated Thurrock Sexual Violence and Abuse group reporting in to the Thurrock Violence Against Women & Girls Strategy Group (it is to be noted that despite the name, this group also address men and boys). This group will provide a focal point for SVA and drive the majority of recommendations from this needs assessment. | Thurrock Community Safety Partnership |
| | Advocate for provision of SVA to be included in the refresh of the Health and Wellbeing Strategy for Thurrock in 2020 so that there is a continued strategic focus on this agenda. | Thurrock Council Public Health Service |
| Locally, there are a number of existing policies, in place, particularly those related to safeguarding, where there is scope to strengthen the presence of SVA to ensure a partnership approach to supporting victims/survivors of SVA working towards prevention and reduction | Thurrock's Adult and Children's Safeguarding Boards should take a proactive approach to addressing SVA, including:<br>-Policies are reviewed and detail clear responses to SVA<br>-Ensuring professional adherence to policies and guidelines<br>-Supporting professionals to feel confident in understanding and addressing SVA. | Thurrock's Adult and Children's Safeguarding Boards |
| | Thurrock's Adult and Children's Safeguarding Boards should support partner organisations to produce policies that address SVA, whether this is included within a generic safeguarding policy or as a standalone policy. This should include:<br>- Training requirements<br>- Information gathering/collection<br>- Information sharing<br>- Safeguarding protocol/standards<br>- Safeguarding supervisions (where appropriate). | Thurrock's Adult and Children's Safeguarding Boards |

# Chapter 1: Introduction

## 1.1 What is sexual violence and abuse?

The World Health Organisation (2010) defines sexual violence and abuse (SVA) 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 or work'[1]. This definition includes rape. As per the Sexual Offences Act 2003 (SOA 2003), rape has legally been defined in the UK as the penetration with a penis of the vagina, anus or mouth of another person without their consent. Rape is defined as 'physically forced or otherwise coerced penetration, even if slight, of the vulva or anus using a penis, other body parts or an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape.

The SOA describes penetration of a person's vagina, mouth or anus with any part of the body other than the penis or with an object without their consent as "assault by penetration". Sexual violence can include other forms of assault involving a sexual organ, including coerced contact between the mouth and penis, vulva or anus. Any sexual activity with or without consent of a child under the age of 16 is an offence, including non-contact activities or encouraging children to behave in sexually inappropriate ways.

It is important to recognise that sexual violence and abuse can happen to anybody, of any age, regardless of gender, sexuality, religion, cultural, social or ethnic background. It should also be understood as a cause and consequence of gender inequality, and as a result, impacts disproportionately on women and girls. SVA may be a one-off event or happen repeatedly over any period of time. In some cases it can involve the use of technology such as phones, internet or social media. SVA can occur anywhere including in public, within the home or workplace and within organisations and institutions such as schools, religious settings and sports clubs. It may also occur when the person is unable to give consent while drunk, drugged, asleep or mentally incapable of understanding the situation.

Child Sexual Abuse (CSA) involves forcing or enticing a child or young person aged under 18 to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Both CSA and Child Sexual Exploitation (CSE) can involve the presence of some form of exchange, i.e. the child receives 'something' e.g. gifts, drugs, alcohol, accommodation or food in return for the sexual activity.[2] In all cases, those exploiting

the child/young person have power over them whether it is by virtue of age, gender, intellect, physical strength and/or economic or other resources. It is important to remember that the victim may have been sexually exploited even if the sexual activity appears consensual.

Over the recent years, the profile of sexual offences has risen significantly due to high profile inquiries such as the Inquiry into Child Sexual Exploitation in the family environment, the Independent Inquiry into Child Sexual Abuse (IICSA) and the Independent Inquiry into Child Sexual Exploitation in Rotherham. Campaigns such as the #METOO movement and high profile media coverage cases involving well known individuals such as Jimmy Savile and Michael Jackson have also contributed to raising the profile of sexually motivated crime. Recently, there has been a significant increase in the number of victim/survivors accessing specialist sexual violence and abuse services. The year ending 2017-18 saw over 6,300 children and adults, predominately women and girls on the waiting lists of Rape Crisis Centres nationally, with the network seeing a 17% increase in survivors accessing support compared to the previous year.[3] It is thought this increase may be attributable to increased willingness to disclose and report and greater awareness of services and support available to cope and recover.

## 1.2 Why is it an important issue?

Being a victim of any kind of crime can be frightening and upsetting however sexual violence and abuse crimes are particularly distressing and devastating crimes for the victim/survivor. The impact of any sexual assault or abuse is largely hidden and often not fully understood, with no identified effects that are unique to these crimes. However, it is well known that the damage and devastation caused is enormous, extremely varied and often lifelong. SVA may have a range of resulting impacts on victims/survivors, as discussed in section 4.3. These impacts may present in different ways for different individuals, with the commonality being serious trauma, which is often compound and complex. The effects of SVA can also incur significant costs to society as demonstrated in sections 4.5 and 4.6. Recently there has also been a significant increase (17%) in the number of survivors accessing specialist support from Rape Crisis Centres.

The demographics of the population and geographical location of Thurrock may be an important factor in the current and future of prevalence sexual violence and abuse. It is to be noted that Thurrock's population is mostly young, with 33% of the population aged under 25 years of age[4] and an average age of 37 years old.[5] The population is set to increase by 20.04% between 2019 and 2041,[6] with a large proportion attributable to migration from London' boroughs and due to Thurrock currently experiencing a large amount of investment and regeneration taking place. Also, whilst we have more children and young people recorded with trafficking as a risk factor compared to other areas (see section 8.3.6), we are unable to conclude for sure whether the geographical location of Thurrock, along the River with ports that can be used as entry and exit points, makes Thurrock a place at greater risk of risk of trafficking compared to other areas. Further information regarding Thurrock as a place can be found in Appendix 1 and a breakdown of its population can be found in Appendix 2.

The video below provides an introduction to the experiences of the survivors interviewed as part of this needs assessment. Their journeys, thoughts and feelings are explored further in the videos that follow throughout this document.

## 1.3 How this needs assessment was conducted

In order to conduct this needs assessment the following processes were undertaken as described below.

| | |
|---|---|
| **Establishment of a Task and finish group** | This group was comprised of key stakeholders including specialist sexual violence and abuse service providers and commissioners, Thurrock Clinical Commissioning Group, safeguarding professionals, Social Care, Community Safety, Essex Police and Public Health staff. The group met regularly and all contributed to the development of this needs assessment. |
| **Reviews of Literature and Research** | Extensive research was conducted in order to gain an understanding of sexual violence and abuse, including the national prevalence, risk factors, impacts of SVA on a victim/survivor and those around them, best practice for supporting victims/survivors of SVA, the legislative framework and commissioning responsibilities and preventative measures. |
| **Information and data requests to local service providers** | Information regarding local service provision and service level data was obtained from specialist sexual violence and abuse services and where possible from non-specialist services. Data and information was also collected from safeguarding services and prevention and perpetrator programmes. |
| **Data analysis** | Data analysis was conducted in order to determine the prevalence of SVA locally and to understand the usage of specialist and non-specialist SVA by local victims/survivors. This also enabled the socio-economic impact of SVA locally to be estimated. |
| **Engagement with local victims/survivors and professionals** | This needs assessment sought to capture the learning from service users and operational and strategic staff in order to further understanding of local experiences of disclosure and service provision. Between 3rd April and 8th May 2019 Healthwatch Thurrock conducted two surveys to seek feedback from victims/survivors in Thurrock and also the professionals across the wider Thurrock workforce. Surveys were available both online and in paper format. A total of 211 responses were received (83 from victims/survivors and 128 from |

| | |
|---|---|
| | professionals). Where appropriate, these insights are included within the needs assessment. |
| **Interviews with victims/survivors of SVA** | In order to obtain deeper insights regarding victims/survivors experiences of SVA, a series of six interviews were conducted. The victims/survivors were asked questions regarding the impacts the SVA had on them and their friends and family, experiences of disclosure, thoughts on the support and services they received and their recommendations and suggestions for future provision. A series of six videos containing interview footage is included within this needs assessment. It is to be noted that all six victims/survivors had accessed specialist SVA services from SERICC. Unfortunately, attempts to recruit victims/survivors who had not accessed support from SERICC services were unsuccessful and therefore this needs assessment is lacking in-depth insights from local victims/survivors who have not accessed specialist support. This requires further exploration in the future. |

The findings and understanding gained from the above has enabled a series of recommendations to be formed which are included throughout the needs assessment. Further to this, the findings have identified the requirement to develop a new vision for future service provision of sexual violence and abuse of which centres around the implementation of a new comprehensive, integrated approach to SVA in Thurrock.

# Chapter 2: National Context and Legislative Framework

## 2.1 Legislative framework

There are two critical pieces of legislation governing the sex offence laws in the UK; the Sexual Offences Act 1956 and the Sexual Offences Act 2003 (England and Wales). The 2003 Act came into force on 1st May 2004 and applies to all offences committed on or after that date. The 1956 Act relates to cases where the offence took place before 1st May 2004 and remains relevant for some non-recent sexual violence and abuse cases. Key offences covered within the Acts include the following where the victim does not consent to the act and where the defendant "does not reasonably believe" that the victim has consented; rape, assault by penetration, sexual assault, causing sexual activity without consent. The age of consent in the UK is 16 and a child under the age of 13 cannot legally consent to any sexual activity and this is therefore classified as statutory rape.

## 2.2 National strategies and guidance

The Istanbul Convention is a comprehensive legal framework that sets out the minimum standards for countries to adhere to in combatting Violence Against Women and Girls (VAWG). It is described as the "gold standard" of legislation on gender-based violence and addresses sexual abuse as well as domestic violence, child marriage and Female Genital Mutilation. Countries that incorporate the treaty commit to ensuring survivors of these crimes can have access to specialist support services and refuges, monitoring data about gender-based violence and having age-appropriate education at schools. The UK signed the convention in 2012 however are yet to ratify it. A 2014 Home Office report stated the UK "will only take steps towards ratification when we are absolutely satisfied that the UK complies with all articles of the Convention".[7]

In 2016 the Home Office issued a National Statement of Expectations regarding Violence Against Women & Girls, which was updated in 2019. The statement sets out what local areas need to put in place in order to ensure their response to sexual violence and abuse (as well as other gender-based violence issues) is as collaborative, robust and effective as it can be so that all victims and survivors can get the help they need (Home Office, 2016). Within this, there are 5 key expectations in regards to local strategies and services:

1. Put the victim at the centre of the strategy
2. Have a clear focus on perpetrators in order to keep victims safe
3. Take a strategic, system-wide approach to commissioning acknowledging the gendered nature of VAWG
4. Are locally-led and safeguard individuals at every point
5. Increase local knowledge of the issues and involve, engage and empower communities to seek, design and deliver solutions to prevent VAWG.

The Ministry of Justice's (MOJ) Victims Strategy (2018) details commitments to support survivors of all crimes including those of a sexual nature. The strategy describes a commitment to increase the availability of services through more joined up and sustainable funding by; working across Government to better align funding for services that support victims/survivors, reviewing effectiveness and increasing and

improving the support for victims/survivors. Plans to achieve this include improving the services and pathways for victims and survivors who seek support from Sexual Assault Referral Centres (SARCs), ensuring better integration between statutory and third sector services in order to provide joined-up and life-long care and support, funding rape services for a minimum of two years and exploring further local commissioning of services to Police and Fire Crime Commissioner (PFCC) to improve support at a local level. The MOJ will also develop commissioning guidance and work with the Association of Police and Crime Commissioners to improve best practice sharing in order to ensure commissioned services meet the specialist needs of sexual violence and exploitation victims.

The NHS (National Health Service) Long Term Plan supports the justice system to provide healthcare support to victims and survivors of sexual assault through the 47 statutory Sexual Assault Referral Centres (SARCs) across England and various other NHS services. The Plan also indicates intentions to expand provision to ensure survivors of sexual assault are offered integrated therapeutic mental health support, both immediately after an incident and to provide continuity of care where needed. New services will be developed for children who have complex needs that are not currently being met; including a number of children who have been subject to sexual assault but who are not reaching the attention of SARCs.

The NHS Strategic Direction for Sexual Assault and Abuse Services outlines how services for victims and survivors of sexual assault and abuse in all settings of the health and care system must evolve between now and 2023. If successfully delivered, it is believed that there will be better health outcomes for victims and survivors, greater value for money and a reduction in: emergency department attendances, GP visits and recidivism of survivors as offenders (both non-sexual and sexual offending). This strategy has been backed by investment from the NHS of £4million per year until 2020/21. The 5 year strategy sets out six core priorities that NHS England will focus on to reduce inequalities experienced, as demonstrated in Figure 1 below.

*Figure 1: Six core principles of the NHS Strategic Direction for Sexual Assault and Abuse Services*

## 2.3 Safeguarding responsibilities

Safeguarding is a term used to denote measures to protect the health, wellbeing and human rights of individuals, which allow people, especially children, young people and vulnerable adults, to live free from abuse, harm and neglect. Safeguarding is recognised as the most effective way to protect children, young people and vulnerable adults against any form of abuse and neglect, including sexual violence and abuse.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect, and outlines local authorities' safeguarding duties. They have the opportunity to intervene early and direct the victim/survivor to the most appropriate statutory and non-statutory services.

The Children's Act 2004 places a statutory duty on all agencies to ensure they have processes in place to safeguard and promote the welfare of children and young people. Health and Social Care professionals have a responsibility to safeguard those known to be vulnerable and those who are placed in the care of others. Measures should be in place to safeguard those who require it and ensure suspicions of SVA are investigated and acted upon where appropriate. If such measures are not in place or acted upon, the risks of SVA become higher. In particular, the risks of re-victimisation and re-traumatisation becomes greater, to the detriment of victim/survivors health and wellbeing.

## 2.4 Commissioning responsibilities

A range of statutory bodies have responsibility for commissioning local and national services to support victims and survivors of sexual violence and abuse (as detailed below).[8] At the national level, these include the Ministry of Justice, Home Office, the Department of Health and Social Care, and NHS England. Locally, Clinical Commissioning Groups (CCGs), Police and Crime Commissioners (PCCs) and Local Authorities all have a responsibility to ensure access to services.

*Figure 2: Commissioning Responsibilities*

**NHS England**

- Sexual Assault Referral Centres (SARCs) – responsible for forensic medical examinations, medical care/support and follow up services in SARCs with Police and Crime Commissioners/Police
- Child and Adolescent Mental Health Services Tier 4 (CAMHS Tier 4)
- Contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for HIV post-exposure prophylaxis following sexual exposure (PEPSE)
- Promotion of opportunistic testing and treatment for sexually transmitted infections (STIs) and patient-requested testing by GPs
- Sexual health elements of prison and Immigration Removal Centre health services
- Cervical screening
- Specialist foetal medicine services

**Clinical Commissioning Group (CCG)**

- Mental Health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of the victims and survivors of sexual assault and abuse, including the third sector
- Most abortion services
- Sterilisation
- Vasectomy
- Non-sexual health elements of psychosexual health services
- Gynaecology, including any use of contraception for non-contraceptive purposes
- Secondary care services, including A&E
- NHS 111
- Sexual health services for children and young people including paediatric care/ support
- Specialist voluntary sector services (in some areas)
- Ambulance/blue light services

**Police and Fire Crime Commission (PFCC)**

- Specific commissioning responsibilities for victims, including victims of sexual assault and abuse
- Specialist voluntary sector services
- (In some forces, the PFCC lead on the procurement of SARC services)

**Local Authority**

- Comprehensive sexual health services, including most contraceptive services and all prescribing costs (excludes additional services commissioned from primary care)
- STI testing and treatment, chlamydia screening and HIV testing
- Specialist sexual health services, including young people's sexual health teenage pregnancy services, outreach, HIV prevention sexual health promotion and services in schools, colleges and pharmacies
- Specialist voluntary sector services

**Ministry of Justice**

- National Male Survivor Helpline
- Rape support services with dedicated emotional and practical support services for victims of rape and other forms of sexual abuse aged 13 or over

**Home Office**

- National Services for victims of child sexual abuse

# Chapter 3: Incidence and prevalence of Sexual Violence and Abuse

## 3.1 National prevalence

Figures for the true prevalence of SVA crimes are difficult to establish, particularly those relating to children and young people. The Crime Survey for England and Wales (CSEW) has been used to provide a robust estimate* of the prevalence of crime since 1981. The survey asks people aged 16-59 living in households in England and Wales about their experiences of crime in the last 12 months. It is to be noted that sexual assaults of those under 16 are not captured within the CSEW. This survey is the preferred measure of trends in the prevalence of sexual assault since this is unaffected by changes in police activity, recording practices and propensity of victims to report such crimes. Sexual assaults measured by the CSEW cover rape or assault by penetration (including attempts), and indecent exposure or unwanted touching and are measured as part of the self-completion module on domestic abuse, sexual assault and stalking.

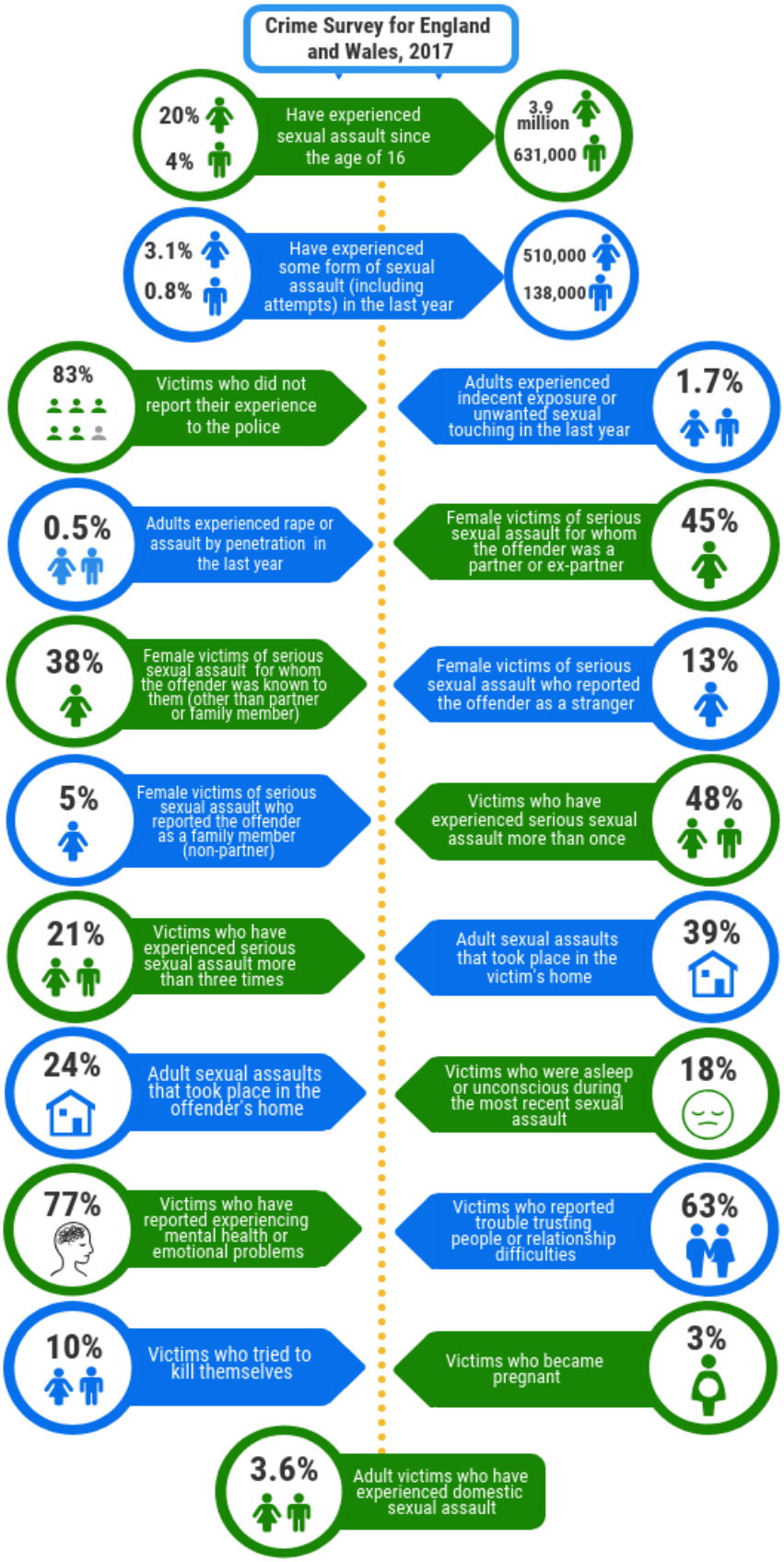
The CSEW estimates that 3.1% of women (510,000) and 0.8% of men (138,000) aged 16 to 59 experienced sexual assault in the last year, and 20% of women and 4% of men have experienced some type of sexual assault since the age of 16, equivalent to an estimated 3.4 million female victims and 631,000 male victims.

It is important to note that the term “sexual assault” in police recorded crime refers to one type of sexual offence, that is, the sexual touching of a person without their consent. This definition differs from the CSEW term of “sexual assault” which is used to describe all types of sexual offences measured by the survey. For this reason, police recorded crime figures are not directly comparable to the CSEW given the broader range of sexual offences covered within police recorded crime (e.g. child sexual exploitation and grooming).

Key findings from the most recent, year ending 2017 CSEW, are summarised in Figure 3 below and have been modelled to the Thurrock population in Figure 7.

* All changes reported, based on the CSEW, are statistically significant at the 5% level unless stated otherwise

*Figure 3: Key findings from the CSEW (2017)*

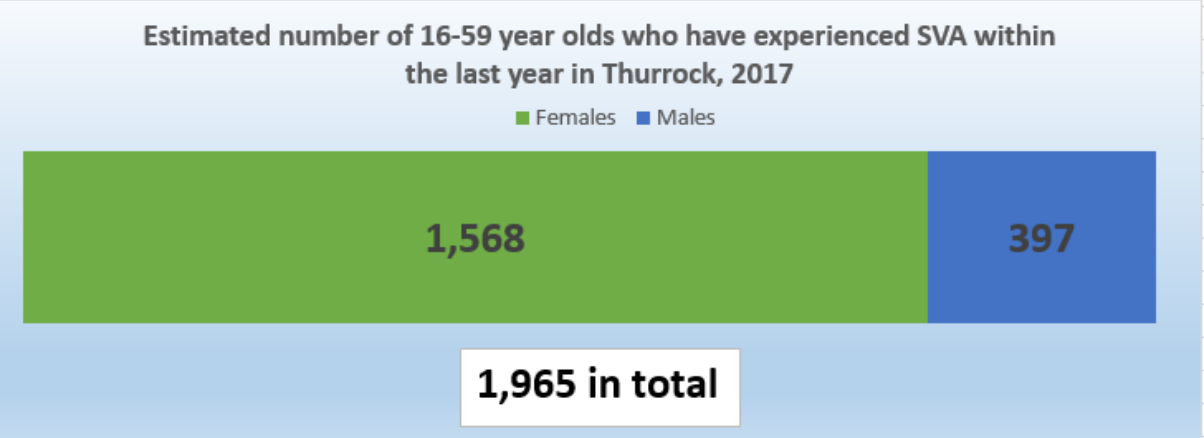


## 3.2 Estimated local incidence and prevalence

Applying the CSEW prevalence estimates (Figure 3) to the local population of Thurrock shows we are likely to have approximately **12,101** people aged 16-59 who have experienced sexual assault since the age of 16 and **1,965** people who have experienced sexual assault in the last year. We can break these down by gender as below:

*Figure 4: Estimated number of Thurrock survivors who experienced SVA since the age of 16*


*Figure 5: Estimated number of Thurrock survivors who experienced SVA in the last year*

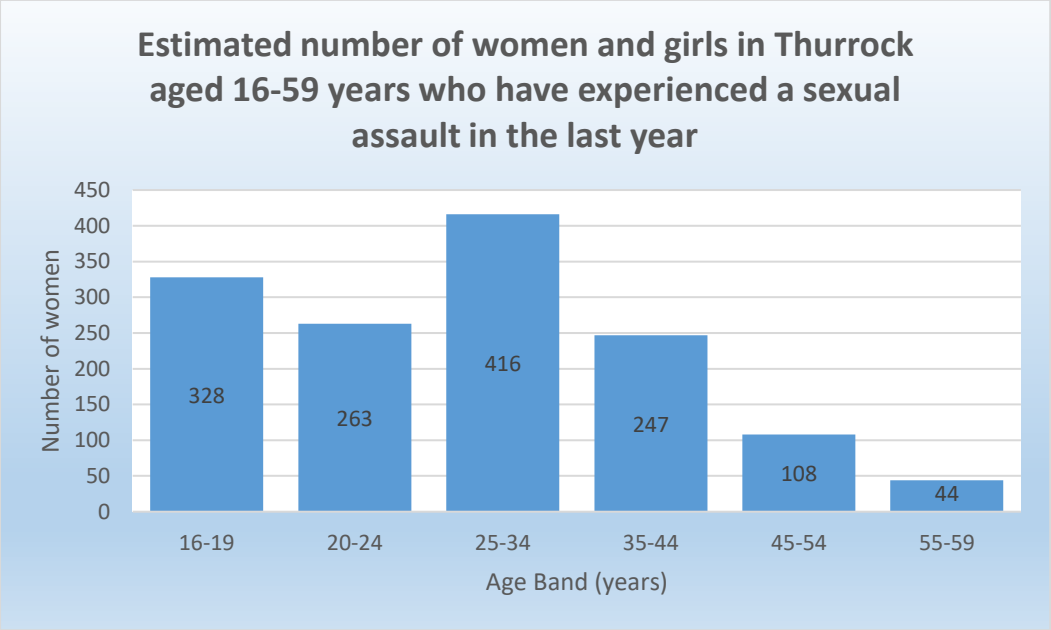



The above estimates are to be used with caution as they only include individuals aged 16-59 years old; however the number of victims/survivors in the 0-15 and 60 and over categories can be estimated using the crime data reported to Essex Police. Police data from 2018 shows that there were a total of 128 reports to the police amongst those aged 0-15 and 60+.[∇] Assuming that this number accounts for 17% of the actual SVA crimes it can be estimated that the actual number of victims/survivors in these age groups is likely to be around 753 and i**t is therefore estimated that the number of Thurrock residents who experienced sexual violence and abuse within the last year is approximately 2,718.**

[∇] In 2018 a total of 128 sexual offences were reported to the Police; 121 were aged 15 and under (F:99 and M:22) and 6 were aged 60 and over, all female.

The *Violence Against Women and Girls Ready Reckoner* tool allows us to apply age-specific prevalence estimates to our local population of females. Figure 6 below depicts the estimated number of women and girls in Thurrock likely to have experienced a sexual assault in the last year by age group. It can be seen that 591 of the victims were aged 16-24 years, equating to roughly 42% of the total estimated number of victims in Thurrock, or a prevalence rate of around 7.2% in that age group. Information about age-specific presence of SVA known to Thurrock professionals is shown in section 7.2.

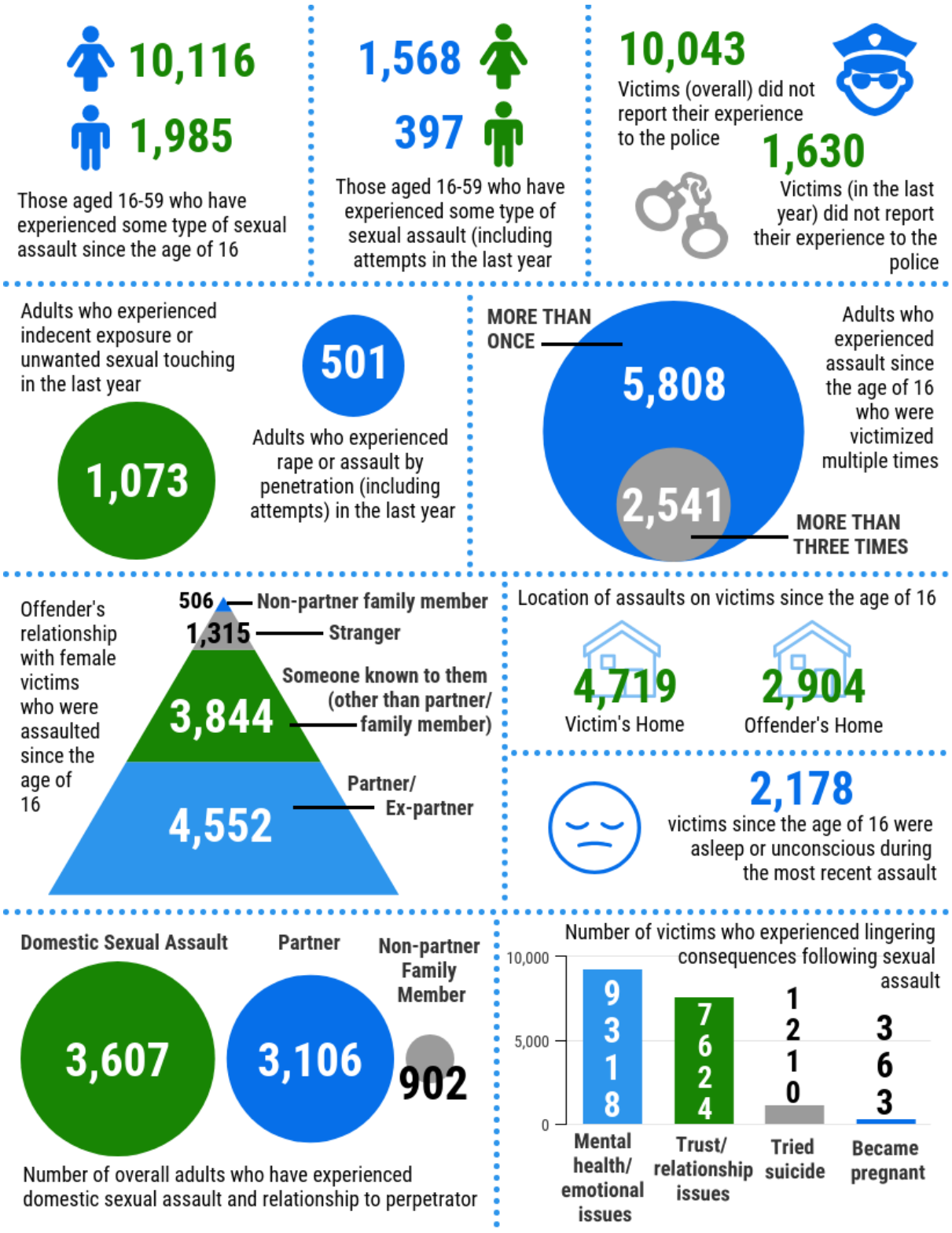
*Figure 6: Number of Thurrock women and girls who experienced sexual assault in the last year*




Source: VAWG Ready Reckoner and ONS Mid-Year Population Estimates

The CSEW findings have been modelled to the Thurrock population in Figure 7 below.

*Figure 7: Crime survey for England and Wales findings modelled to the Thurrock population*


10,116
1,985
Those aged 16-59 who have experienced some type of sexual assault since the age of 16
1,568
397
Those aged 16-59 who have experienced some type of sexual assault (including attempts in the last year
10,043
Victims (overall) did not report their experience to the police
1,630
Victims (in the last year) did not report their experience to the police
Adults who experienced indecent exposure or unwanted sexual touching in the last year
1,073
501
Adults who experienced rape or assault by penetration (including attempts) in the last year
MORE THAN ONCE
5,808
2,541
MORE THAN THREE TIMES
Adults who experienced assault since the age of 16 who were victimized multiple times
Offender's relationship with female victims who were assaulted since the age of 16
506
Non-partner family member
1,315
Stranger
3,844
Someone known to them (other than partner/ family member)
4,552
Partner/ Ex-partner
Location of assaults on victims since the age of 16
4,719
Victim's Home
2,904
Offender's Home
2,178
victims since the age of 16 were asleep or unconscious during the most recent assault
Domestic Sexual Assault
Partner
Non-partner Family Member
3,607
3,106
902
Number of overall adults who have experienced domestic sexual assault and relationship to perpetrator
Number of victims who experienced lingering consequences following sexual assault
10,000
5,000
0
9318
7624
1210
363
Mental health/ emotional issues
Trust/ relationship issues
Tried suicide
Became pregnant

## 3.3 Implications of local data

These local figures modelled from the CSEW provide a bit more insight into the experiences our survivors might have had. Some of the key inferences for us locally are listed below:

- In excess of 10,000 victims/survivors who have experienced SVA in their adult life have not reported it to the Police. Whilst it is not possible to say for certain that these survivors would not have access to support to help them cope and recover from the effects of SVA, these may have been missed opportunities to offer appropriate support services at the earliest opportunity.

- 4,719 of victims/survivors who were assaulted since the age of 16 were assaulted in their own home. This is of importance as it highlights that the majority of perpetrators of SVA are known to the victim/survivor, contrary to the 'stranger danger' myth that is often associated with sexual assault. This may also be linked to a higher incidence of repeated assaults or abuse as the victim/survivor and perpetrator are likely to have repeated contact.

- Over 9,300 victims/survivors have experienced mental health/emotional issues following their sexual assault which may have significant impacts on their personal lives and also pressure on the health sector, as described in sections 4.5 and 4.6.

- Of the adults who experienced sexual assault since the age of 16; over 5,800 were assaulted more than once, and of which over 2,500 were assaulted more than three times. This may indicate missed opportunities for disclosure, help seeking and prevention of further assault or abuse.

Although the CSEW modelling to the Thurrock population provided in Figure 7 provides some estimations as to the number of Thurrock victims/survivors who may experience negative impacts following their experience of SVA, the local data available did not allow us to fully understand the impacts and lingering consequences for victims/survivors and also local services, including but not exclusive to; mental health provision, sexual and reproductive health, termination of pregnancy, education, Social Care, benefits and housing support.

## 3.4 Barriers to determining accurate local data

### 3.4.1 Data recording

During the development of this needs assessment, inconsistencies were noted in the recording of data related to sexual violence and abuse across a number of organisations in Thurrock. It was only the Police and specialist sexual violence and abuse services that were able to provide robust data that contributed to our understanding of known sexual violence and abuse locally.
The following matters in particular were identified:

- Information is often lost within a patient/service user's case notes, particularly within free text boxes (this was particularly apparent within Social Care notes)

- Certain databases/systems (particularly within General Practice and hospital settings) are only able to record one primary need at a time and often this is recorded as the presenting symptom and not the cause (e.g. bruises and not sexual assault)

- Staff are not aware of the codes that can be used to record SVA and therefore these are not being utilised, particularly in health settings

- Organisations are only able to record information that the patient/service user discloses or is willing to share.

- Some organisations also mentioned specific concerns regarding their patients/ service users not reporting their experience of SVA or not recognising that they had been a victim of SVA and therefore this is left unreported.

### 3.4.2 Data sharing

It was also identified that data related to sexual violence and abuse is seldom shared locally. Data sharing arrangements, whether formal or informal, are not consistent amongst organisations in Thurrock. However, a particular example of good practice identified locally is the Memorandum of Understanding (MoU) that has been developed at a county-wide level in order to set out the joint co-operation between residential and foster care providers and police, as supported by the Southend, Essex and Thurrock (SET) Local Authorities. The MoU seeks to improve the quality and timeliness of information sharing between carers and providers with Essex Police relating to children at risk of going missing from care, being trafficked, who are gang associated and at risk, or who have been and / or are victims of CSE. The expected outcome is that with prior shared key child-level information, the location and safeguarding of missing children will be expedited. Compliance with the MoU is due to be reflected in the revised SET Child Protection Procedures and Providers will be subjected to checks to ensure that requirements contained in the MoU are complied with.

### 3.4.3 Recommendations to address known issues with data collection

It is imperative that we improve local data collection in order to further our understanding of SVA locally. For this to be possible, the following recommendations are suggested:

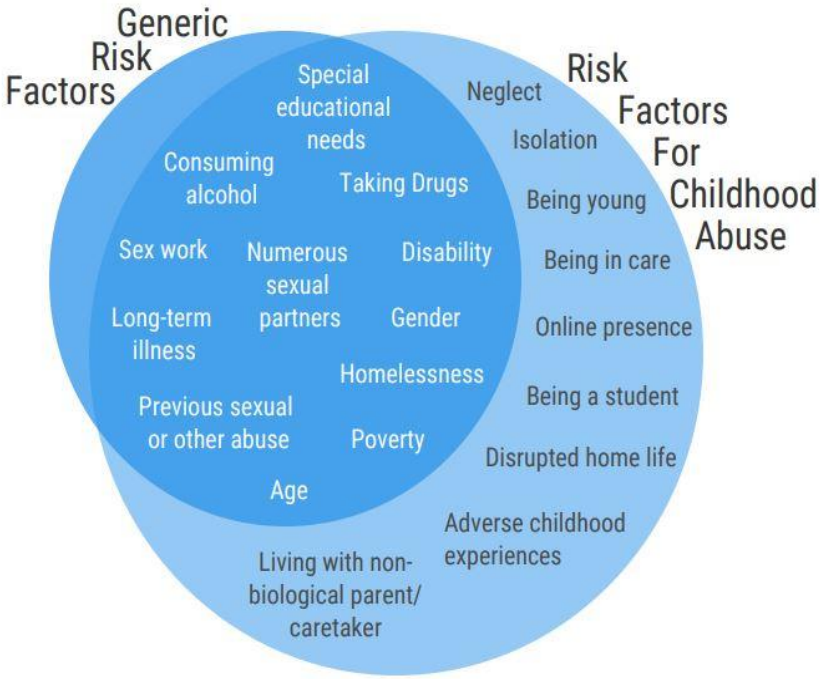
| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations around improving data** | | |
| Locally there are low levels of reporting of SVA crimes to the Police. Although this is observed nationally, the Thurrock rates are lower than comparable authorities (see chapter 7 for further information) | The Essex Sexual Abuse Strategic Partnership should commission dedicated SVA campaign work s in order to increase public confidence in reporting crimes, which in turn should reinforce positive outcome messaging. | Essex Sexual Abuse Strategic Partnership (working with Essex Police and Crown Prosecution Service) |
| Data collection mechanisms are not currently set up to enable identification of the number of survivors accessing all agencies in Thurrock | Non-specialist SVA organisations (e.g. sexual health, mental health, drug and alcohol services) should embed questions related to SVA in to their relevant templates/assessments in order to improve identification of SVA survivors. | All relevant non-specialist SVA organisations, to be determined and overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| The systems/ databases/ datasets used by some organisations locally are not appropriately set up to record SVA related information. | Relevant agencies including General Practice, hospitals, sexual health, mental health provider NHS trusts, drug and alcohol treatment services, and domestic abuse services should develop a single, consistent recording protocol in order to facilitate disclosures and identify SVA survivors. This protocol should include:<br>- the use of mandatory questions<br>- appropriate datasets<br>- appropriate coding/categories<br>- minimising opportunities for SVA to be lost within free text sections of case notes.<br>For health settings, this may be most effective at a Mid & South Essex STP (Sustainability and Transformation Partnership) approach considering the shared resources i.e. hospitals, Police force, Single Point of Access for Rape Crisis Centres). | To be overseen by the Thurrock Sexual Violence & Abuse Stakeholder Partnership with support from relevant organisations |
| Due to inconsistent data capturing across organisations, it is difficult to identify victims/survivors use of services and their pathways between services (e.g. at what point they access support, type and frequency of support received, the duration support was received for) | The Thurrock SVA Stakeholder Partnership should undertake baseline mapping activity to identify current data recording practices within each agency around service usage in order to make adaptations to reporting requirements and data collection. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |

# Chapter 4: Risk factors for, and impact of SV and abuse

## 4.1 Risk factors

Any child or adult can be a victim of sexual violence or abuse; however it is recognised that sexual violence and abuse crimes tend to disproportionately affect the most vulnerable in society. There are a range of personal and environmental factors that make certain individuals more susceptible to SVA. The vast majority of risk factors are relevant to both children and adults however some may be more applicable to certain age groups, as demonstrated in Figure 8 below.

*Figure 8: Risk factors for SVA*[9]




Perpetrators of sexual violence and abuse offences may target children who don't have many friends or lack attentive parents as this can facilitate access and manipulation, however, those who are not vulnerable and have attentive parents can also become victims. It is well recognised that the internet and social media are places where children can be met, sexually groomed and persuaded to provide sexual imagery.[10]

### *Gender*

Risk factors vary depending on gender.[11] Girls are at greater risk of being sexually abused by a family member and women are at greater risk if they have low educational attainment or were exposed to their mother being abused by a partner.[12] Young boys are at greater risk of sexual abuse from strangers, institutional and clergy abuse as children, and prison-based sexual violence as adults.[13] The World Health Organisation (WHO) recognise being married or co-habiting as a risk factor, however the Office of National Statistics (ONS) cite being single a risk factor, indicating further insight is required to understand the nature of relationship in sexual assault.

### *Age*

Age is also an important factor, with girls aged between 15 and 17 years reporting the highest rates of sexual abuse in the UK.[14] Children aged 12-15 are most at risk of child sexual exploitation although victims as young as 8 have been identified, particularly in relation to online concerns.[15] While some victims/survivors who were sexually groomed as children continue to be sexually abused as adults, others who are vulnerable can also be open to exploitation and sexual abuse starting in adulthood, particularly as young adults. This is often as a result of heightened vulnerability, although not always.

### *Vulnerabilities*

A review on the prevalence and risk of violence against children with disabilities, published in July 2012, found that overall children with disabilities are 2.9 times more likely to be victims of sexual violence than non-disabled children. Children with mental or intellectual impairments appear to be among the most vulnerable, with 4.6 times the risk of sexual violence compared to their non-disabled peers.[16]

Adults with disabilities are at a higher risk of all types of violence than are non-disabled adults, and those with mental illnesses could be particularly vulnerable. This finding is generally applied to sexual violence, however, there is a lack of robust evidence about specific types of violence. A review and meta-analysis found the risk of violence in disabled adults was 1.5 times higher than non-disabled individuals, 1.31 times higher for people with non-specific impairments, 1.6 times higher for people with intellectual impairments, and 3.86 times higher for those with mental illnesses.[17]

Factors which place people with disabilities at higher risk of violence include stigma, discrimination, and ignorance about disability, as well as a lack of social support for those who care for them. Placement of people with disabilities in institutions also increases their vulnerability to violence. In these settings and elsewhere, people with communication impairments are hampered in their ability to disclose abusive experiences.[18]

In addition to this, young or disabled children and adults may find it harder to protect themselves, to tell somebody what's happening or seek help, or to even recognise they are being sexually abused. They may also have fewer, if any, opportunities to disclose, particularly if they are socially isolated or have none or limited opportunities to see health or social care professionals without the abuser present. It is to be recognised that a range of other vulnerabilities also exist, e.g. working in the sex industry, mental health and self-harm and this is not an exhaustive list.

## 4.2 Associated links with SVA

There are links between SVA and other forms of abuse and criminal activity, including but not limited to those described below:

### Domestic Violence

There is evidence suggesting the presence of physical abuse increases the likelihood of sexual violence and general domestic violence (all violence within the family setting) increases the likelihood of child sexual abuse in the home.[19] In the year ending March 2018, the Crime Survey for England and Wales (CSEW) estimated that 2 million adults aged 16-59 experienced domestic abuse, equating to a prevalence rate of

approximately 6 in 100 adults. Women were around twice as likely as men to have experienced domestic violence (7.9% compared with 4.2%) equivalent to 1.3 million female victims and 695,000 males. This measure of domestic abuse combines partner abuse (non-sexual), family abuse (non-sexual) and sexual assault or stalking carried out by a current or former partner or other family member and do not take into account the context and impact of the abusive behaviours experienced. Domestic sexual assault was experienced by 0.3% of adults aged 15-69 in the last year; 0.2% of adults had experienced sexual assault by a partner and 0.1% had experienced sexual assault by a family member. Evidence suggests that different types of violence may occur simultaneously in the same family, and that the presence of one form of violence may be a strong predictor of the other.[20]

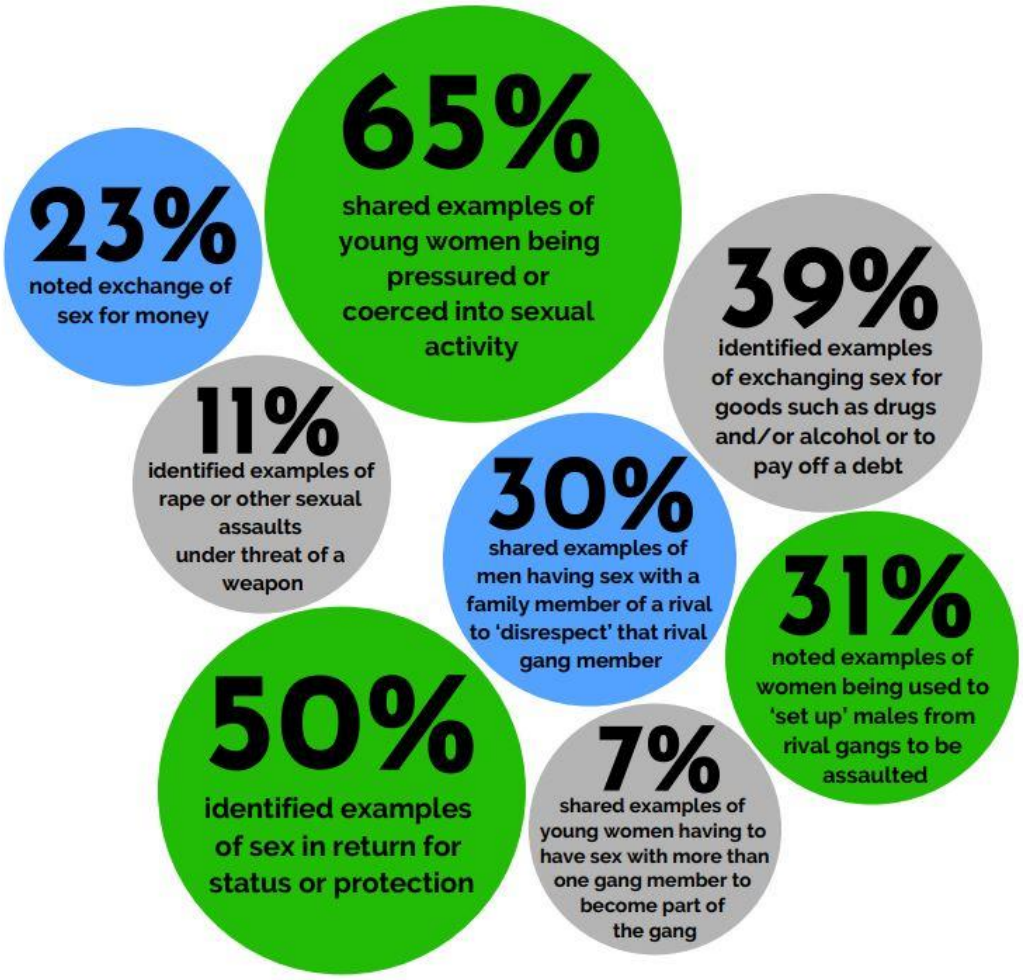
### Substance Misuse

There is a strong link with drug and/or alcohol consumption and SVA crimes as they can be used to facilitate or make an individual more vulnerable to sexual assault/violence/abuse. Alcohol is the most common substance used to facilitate sexual assault with approximately half of all reported sexual assaults involving alcohol consumption by the perpetrator, the victim/survivor or both.[21] Drugs (including 'date-rape' drugs) may be used surreptitiously by perpetrators to facilitate sexual assaults but more frequently a victim's own willing substance use is exploited. In both situations, the role of drugs/alcohol is to increase a victim's vulnerability to sexual assault by impairing their ability to consent. The stress and trauma of sexual violence or abuse can lead victim/survivors to self-medicate with drugs and/or alcohol leading to addiction or dependence. Unfortunately, this particular coping mechanism puts victim/survivors at higher risk of re-victimisation and disadvantages them further within society with the double stigmas of sexual victimisation and substance user.[22]

### Gangs

The significant problem of sexual violence within organised gangs is both part of the power structure within gang culture as well as a reflection of sexual violence that occurs in wider society but is further amplified by the hyper-masculine gang environment. Young women are particularly vulnerable to gang-associated sexual violence and exploitation. A 2013 research study by the University of Bedfordshire [23] explored the links between sexual violence and abuse and gang activity amongst 188 young people. Key findings are presented in Figure 9 below.

*Figure 9: Key findings from research regarding Gangs and SVA*




It is to be noted that wording used within this infographic is that used by the researchers and respondents within the study. In the majority of these cases, the law may define these incidents as rape or sexual assault as consent was not freely given.

There is likely sexual violence used against both males and females in gangs, however there is a lack of evidence to support this due to associated stigma and lack of reporting. While the sexual violence within gang settings is horrific, incidents are often not reported and they are somewhat normalised amongst those who live day-to-day with gangs. There is also a high level of fear of retribution for reporting an incident and an overall lack of confidence that services can/will do anything to help or protect victims.

### Trafficking/Sex Trafficking

In the UK, human trafficking falls under the term Modern Slavery and is defined within the Modern Slavery Act 2015. These crimes include holding a person in a position of slavery, servitude forced or compulsory labour, or facilitating their travel with the intention of exploiting them soon after. Human trafficking is often thought of as an international crime, but it is also possible to be trafficked within a country, the UK included. Trafficking is normally more prevalent among the most vulnerable or within minority or socially excluded groups. Poverty, limited opportunities at home, lack of education, unstable social and political conditions, economic imbalances and war are

some of the key drivers that contribute to someone's vulnerability in becoming a victim of trafficking.[24] Trafficking for the purpose of sexual exploitation and child sexual exploitation has seen 4.8 million people worldwide forced into sex work with 99% of these being women and girls, though men and boys can also be victims.[25] Sexual exploitation involves any non-consensual or abusive sexual acts performed without a victim's permission; this includes prostitution, escort work and pornography. Many victims are deceived with promises of a better life and then controlled through violence and abuse. Sexual abuse can be used by traffickers as a way of grooming and entrapping both adults and children into trafficking by convincing them they are in a genuine loving relationship or else it can be used as a way to subdue and control victims.[26]

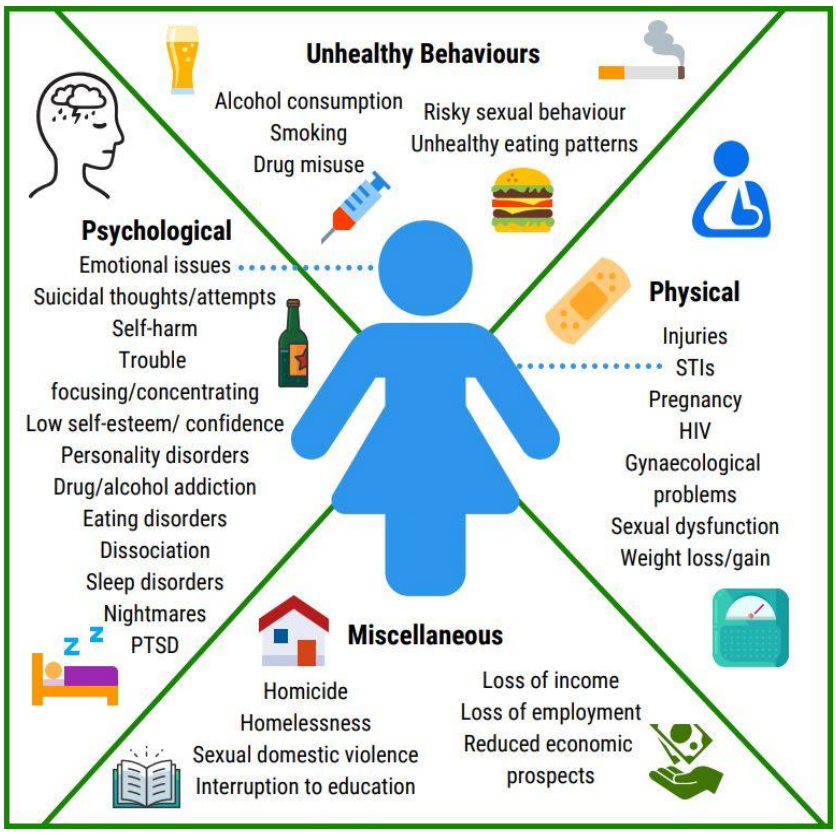
## 4.3 Impacts of sexual violence and abuse

For victims/survivors, these crimes represent a violation and can have significant and ongoing consequences for health and wellbeing. As a direct result of the trauma, survivors of sexual violence and abuse may suffer from a variety of physical, mental, behavioural and relationship impacts (see Figure 10 for examples) in the short, medium and long term, even over a lifetime.[27] Many victims/survivors of sexual violence or abuse cope with this trauma by using drugs, drinking alcohol, smoking, or overeating. Research shows that about 90% of women with substance use problems had experienced physical or sexual violence.[28]

Adults with a history of CSA are more likely than the general population to experience physical health problems including diabetes, gastrointestinal problems, arthritis, headaches, gynaecological problems, stroke, hepatitis and heart disease.[29] It has been suggested that these poorer outcomes are due to the impact that early life stress has on the immune system or to the greater propensity for adult CSA victims/survivors to engage in high-risk behaviours e.g. smoking, alcohol abuse and risky sexual behaviours.[30]

Impacts vary from person to person and present in different ways for different individuals. Both men and women suffer from the common adverse effects and there is no difference in the severity of effects. However, male victims of sexual violence and abuse can be more confused about their sexual orientation following sexual abuse because their perpetrators are predominantly men. Women and girls experience a general 'fear' of men, which also has an impact on their intimate relationships. For women and girls who are subject to inequalities of race, class, poverty and/or are part of a particular monitoring group (e.g. traveller or migrant communities) these issues can be compounded by multiple, intersecting inequalities.[31]

*Figure 10: Impacts of SVA on victims/survivors32*




### 4.3.1 Impacts on adults who were sexually abused as children (Adult survivors)

The effects of Child Sexual Abuse (CSA) are not always obvious during either childhood or in adulthood. The Independent Inquiry into Child Sexual Abuse (IICSA) runs the Truth Project. Research from the Truth Project revealed that victims of CSA carry their experiences in to adulthood, though there is variation between individuals both in terms of when problems emerge as well as what those difficulties are.[33] Not all survivors of sexual abuse show poor outcomes as adults; however it is associated with increased risk of anxiety disorders, depression, eating disorders, Post-Traumatic Stress Disorder (PTSD), sleep disorders and suicide attempts (see further information in section 4.3.2).

CSA can also lead some victims/survivors to be particularly protective of their loved ones, particularly children and grandchildren.[34] Many factors can influence whether a victim/survivor will show problems in later life and include; the age of the victim at the time, the type, frequency and duration of the abuse and the relationship with the perpetrator.[35]

### 4.3.2 Impacts on mental health

Experiences of sexual violence and/or abuse can be deeply traumatic and victims/ survivors are at greater risk of a variety of short and long term mental health issues. The information in

Table 1 below, taken from the 2016 'Hidden Hurt' Report[36] unless otherwise stated, shows how much greater the likelihood of certain common mental health conditions are if someone has experienced sexual violence/abuse.

*Table 1: Common mental health conditions in victims/survivors of SVA*

| Vulnerability | Prevalence (%) within SVA survivors |
|---|---|
| **Common mental disorder (including depression and anxiety)** | 32% |
| **Multiple (3+) mental disorders** | 10% |
| **Post-traumatic stress disorder (PTSD)** | 16% |
| **Borderline Personality Disorder** | 15.6% (mid-point of range)* |
| **Self-harm (at least one attempt ever)** | 56% |
| **Suicide attempts** | 10% |
| **Substance misuse problems** | 38% |
| **Eating disorders** | 3% |
| **Financial crisis** | 12% |
| **Homelessness (ever experienced)** | 6% |

*Referenced in section below

### *Borderline Personality Disorder (BPD) and SVA*

There is a lot of published research that indicates SVA is frequently present in patients with BPD. BPD is a mental disorder which seems to result from an interaction between biological and psychosocial factors, and is characterised by instability with emotional regulation, relationships with others, self-image and impulse control.[37] A review by de Aquino Ferreira et al. [38] found that the prevalence of CSA within BPD patients ranged from 16.1-85.7%, and that between 1.8-29.3% of CSA victims/survivors have BPD. Narrowing down the extent of the overlap is further complicated by the fact that **symptoms of BPD overlap with complex PTSD, which as above is also associated with SVA.** This study also found that the presence of SVA in a BPD patient was a predictor for increased severity of clinical presentation and poorer prognosis. In addition, the authors found that a BPD patient with a history of CSA was 10 times more likely to attempt suicide than a non-CSA BPD patient.

### *Inpatient admissions and SVA*

A 2014 review by Quadrio[39] looked at a number of studies of those admitted to mental health inpatient units, and identified that a high proportion of them had experienced sexual abuse within their childhood. On average, half (50%) of female inpatients had experienced CSA and over a quarter (28%) of male inpatients had experienced CSA.

## 4.3.3 Impacts of SVA on relationships with family/friends

Research has found that positive social responses to disclosure of sexual violence and abuse are associated with better individual coping for victim/survivors while negative responses can cause “secondary trauma” and lead to more severe poor outcomes.[40] Anger, disbelief, victim blaming and even disownment can be reactions of family members, often when the abuse/assault was perpetrated by a relative or when the relatives knew the sexual abuse was taking place but failed to intervene. Victims/survivors may even be pressured to lie about the incidence of sexual abuse to protect the perpetrator. Negative responses to disclosure can have ripple effects for victims/survivors’ capacity for trust or self-worth in the future which can put them at risk for further sexual violence/abuse. CSA victims/survivors may also feel responsible for possible changes to family dynamics and the wellbeing of family members.

Disclosures may also disrupt friendship groups and cause difficult relationships with friends and peers that may result in bullying, isolation and loneliness.[41] Those with closer relationships to the victim/survivor (i.e. partners, family and close friends) are known to experience guilt and secondary trauma themselves, and in some cases and may not respond appropriately to a disclosure and may also require support themselves to cope with the knowledge of the SVA.[42] The mental health of parents/ carers can also be affected if they felt responsible for having been powerless and unable to protect their child.[43] Locally, survivors spoke of how their experiences of SVA impacted those around them with common responses including difficulties maintaining relationships with families, friends and partners and in some cases loss of relationships and difficulties parenting. Quotes are included below:


## 4.4 User voice on impact

Locally, victims/survivors spoke of how sexual violence and abuse impacted their lives. Most survivors reported multiple impacts which ranged amongst survivors, including impacts on their relationships (particularly the ability to form or maintain healthy relationships), various mental health issues, the ability to parent, ability to work, lack of ability to trust others and lack of sleep. Examples of the impacts experienced by local survivors are included below:


The video below provides accounts of the impacts of sexual violence and abuse on local victims/survivors.

## 4.5 Socioeconomic costs

The socioeconomic costs of sexual violence and abuse manifest as both tangible and intangible costs as well as direct and indirect costs. Tangible costs of SVA are taken to include direct costs such as:

- Medical care
- Physical health
- Sexual health
- Pregnancy
- Mental health services
- Housing/Refuge
- Administration costs
- Police investigations
- Criminal prosecutions
- Costs associated with the correctional system

Indirect costs may also occur through employee's loss of productivity and income and personal financial losses due to injury or inability to work.

Intangible costs are taken to include the psychological pain and suffering of victims/survivors, and a generalised, heightened fear of victimisation which may impact on ability to function normally and achieve aspirations. Many costs can stretch on for years following an incident. Adults with a history of abuse as a child, especially sexual abuse, are more likely than people with no history of abuse to become frequent users of GP, emergency and medical care services.[44]

Many of these costs were not available specifically for SVA survivors. However the table below looks to break down as many elements of the mental health service costs as possible and are shown as an annual estimated cost per person. The majority of these costs were taken from the Saied-Tessier (2014)[45] report unless otherwise stated.

*Table 2: Yearly costs associated with CSA*

| Co-morbidity | Estimated annual service cost per survivor |
|---|---|
| **Common mental disorder (including depression and anxiety)** | £332 |
| **Multiple (3+) mental disorders** | *Unable to quantify* |
| **Post-traumatic stress disorder (PTSD)** | £1,040 |
| **Borderline Personality Disorder** | £14,909[46] |
| **Self-harm attempts** | £2,094 |
| **Suicide attempts** | £2,094 |
| **Substance misuse problems** | £454 (drug) - £920 (alcohol) |
| **Eating disorders** | £8,900 (inpatient admission)[47] |

Given that these calculations are missing out large areas where direct and indirect costs may occur, we must assume these as extremely conservative estimates for potential economic impacts.

When considering potential costs to be avoided through better prevention of SVA or management of survivor needs, the other substantial 'cost' is the cost to one's emotional wellbeing following SVA. Human Impact, both emotional and physical, is the estimated equivalent price someone would pay to avoid the suffering caused by an incident of sexual violence, and therefore does not necessarily represent actual money paid. Research by Oliver et al. (2019)[48] estimates this figure to be **£62,180** per rape and **£10,561** per other type of assault.

## 4.6 Estimated socioeconomic cost of SVA in Thurrock

The tables below aim to apply both the estimated incidences of these other co-morbidities/vulnerabilities quantified above, and their approximate costs to the total number of SVA survivors in Thurrock, in order to begin to quantify the likely local impacts to wider services. It should be noted that these are conservative estimates, as survivors may not necessarily disclose associated conditions, and they may not be accessing treatment (or they may access privately-funded treatment). The first table applies the prevalence and cost estimates to the number of survivors estimated to have experienced SVA within the last year aged 16-59 years (1,965 people); and the

second table applies these to the total number of survivors who have ever experienced SVA aged 16-59 years (12,101 people).

*Table 3: Estimated number of SVA survivors in Thurrock with specific vulnerabilities and annual cost of treating these (abused within the last year)*

| Symptom/mental health issue | Prevalence (%) within SVA survivors | Estimated number of survivors with this co-morbidity | Estimated annual treatment cost (assuming they all access NHS treatment) |
|---|---|---|---|
| **Common mental disorder (including depression and anxiety)** | 32% | 629 | £208,828 |
| **Multiple (3+) mental disorders** | 10% | 197 | *Unable to quantify* |
| **Post-traumatic stress disorder (PTSD)** | 16% | 314 | £326,560 |
| **Borderline Personality Disorder** | 15.6% (mid-point of range) | 307 | £4,577,063 |
| **Self-harm (at least one attempt ever)** | 56% | 1,100 | £2,303,400 |
| **Suicide attempts** | 10% | 197 | £412,518 |
| **Substance misuse problems** | 38% | 747 | £513,189 |
| **Eating disorders** | 3% | 59 | £524,655 |
| **Financial crisis** | 12% | 236 | - |
| **Homelessness (ever experienced)** | 6% | 118 | - |

*Table 4: Estimated number of SVA survivors in Thurrock with specific vulnerabilities and annual cost of treating these (abused since the age of 16)*

| Symptom/mental health issue | Prevalence (%) within SVA survivors | Estimated number of survivors with this co-morbidity | Estimated annual treatment cost (assuming they all access NHS treatment) |
|---|---|---|---|
| **Common mental disorder (including depression and anxiety)** | 32% | 3,872 | £1,285,504 |
| **Multiple (3+) mental disorders** | 10% | 1,210 | *Unable to quantify* |
| **Post-traumatic stress disorder (PTSD)** | 16% | 1,936 | £2,013,440 |
| **Borderline Personality Disorder** | 15.6% (mid-point of range) | 1,888 | £28,148,192 |
| **Self-harm (at least one attempt ever)** | 56% | 6,777 | £14,191,038 |
| **Suicide attempts** | 10% | 1,210 | £2,533,740 |
| **Substance misuse problems** | 38% | 4,598 | £3,158,826 |
| **Eating disorders** | 3% | 363 | £3,230,967 |
| **Financial crisis** | 12% | 1,452 | - |
| **Homelessness (ever experienced)** | 6% | 726 | - |

The Thurrock data modelled from the CSEW in Figure 6 showed that over 9,300 victims/survivors have experienced mental health/emotional issues since their SVA incident/incidents. This indicates there are likely to be several thousand survivors who are experiencing mental ill-health but not at a diagnosable threshold to be counted in the figures above.

# Chapter 5: Preventing Sexual Violence and Abuse

It is of paramount importance that we prevent sexual violence and abuse from happening at all. For victims and survivors of previous incidents we must also reduce the risk of future re-victimisation is central to their recovery, healing, ability to rebuild their lives and ongoing safety.

Although it is likely that prevention programmes will not eradicate sexual violence entirely, it may contribute to a reduction in sexual offences. In order to do so, we must challenge social norms, attitudes and behaviours and reduce the stigma that surrounds talking about sexual violence and abuse. This requires changing individual behaviours on a scale that produces a culture shift; to this end, there is evidence (laid out below) of effective interventions at different levels (universal prevention, targeted prevention for individual groups at risk, and interventions aimed at perpetrators). A multi-layer approach will ensure the broadest coverage for prevention and re-offending efforts.

Research in to the management of sex offenders in the UK has suggested that sexual offending should be reframed in a public health context around education as well as outreach and support for potential perpetrators, supporting current interventions and treatment programmes. [49] Such an approach should entail a coordinated range of multi-faceted interventions, especially given the estimated costs of sexual offences as detailed in sections 4.5 and 4.6. Three levels of a Public Health approach have been identified and are described below:[50]

- Primary prevention around education to recognise the signs of sexual abuse
- A secondary level of targeted prevention around help and education for individuals who could (potentially) commit a sexual offence with aim to prevent them from committing an offence in the future
- A tertiary level about the wider integration for offenders convicted of a sexual offence, which protects the public and reduces re-offending.

## 5.1 Evidence base

### 5.1.1 School-based Programmes

Interventions focused on relationships involve helping people understand the nature of healthy relationships and how they might ensure that themselves and others have safe and respectful interactions. They also empower people to look out for those around them. Healthy Relationships Programmes aim to educate, inform and challenge young people about healthy relationships, including abuse, consent and relationship abuse. Programmes also aim to build young people's awareness of known issues such as pornography, consent, sexual violence and abuse, harmful sexual behaviours and relationship abuse. Provision often varies between schools however this will be supported by the implementation of mandatory Relationships Education programmes in primary schools and Relationships and Sex Education programmes in secondary schools from September 2020.

### 5.1.2 Targeted prevention

It is important that prevention activities are also targeted at those who are displaying signs of unhealthy relationships and harmful sexual behaviours in order to deter them from going on to commit sexual offences. Such programmes aim to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence

and aim to ensure no-one is unnecessarily referred to specialist services. Approaches used may include the use of CBT and multi-systematic therapy for problematic sexual behaviour. Recognised treatment resources or guided interventions include the AIM and AIM2 programmes, which provide a framework for information gathering along with a toolkit of interventions. Guidance from the National Institute for Health and Care Excellence (NICE) was published in 2016 regarding harmful sexual behaviour among children and young people.

### 5.1.3 Prevention aimed at perpetrators/offenders

Individuals convicted of a sexual offence and given a custodial sentence undertake a risk assessment process in order to determine their eligibility for any prison programme to be completed as part of their sentence. Programmes known as Sex Offender Group work Programmes may also be undertaken through probation and may form part of a community sentence or as a condition of a prison license. A number of offender treatment programmes were available for those convicted of sexual offences, including; the Core Sex Offender Treatment Programme (Core SOTP), and the Healthy Sex Programme. Studies have explored the effectiveness of sex offender programmes, with some evidence suggesting that individuals who received treatment having lower reconviction rates than those who do not.[51] Research also indicates that CBT is the most effective method of treatment compared to counselling or non-behavioural treatment[52].

## 5.2 Local provision

*Relationships and Sex Education*

Thurrock Council's Public Health Department commission Brook to support schools deliver the Relationships and Sex Education curriculum. This offer includes the delivery of classroom based targeted education sessions, drops in and teacher training delivered in secondary schools. Topics relevant to the sexual violence and abuse agenda include; healthy relationships, self-esteem, sexuality and porn pressure and consent. In the 2018/19 academic year, these sessions were delivered to approximately 575 students.

*The Good Man*

The Good Man Project is a male-mentoring programme (The Good Man Project) delivered by the Essex County Council Youth Services. This is a 5-week programme that can be delivered in a group or one-to-one, for young men aged 13-18 who are at risk of entering into abusive relationships. The programme aims to educate participants to show respect in relationships, and what differentiates a healthy relationship from an unhealthy one. Since 1st April 2019, 14 referrals for one-to-one support have been received from Thurrock agencies, with 5 of those currently still waiting for support. Group work is underway in four of our secondary schools over the course of this academic year, and schools have been incredibly supportive with this.

*Thurrock Youth Offending Team*

The Thurrock Youth Offending Service (YOT) will assess all offenders convicted of a sexual offences using the AIM 2 specialist assessment, as described above as best practice. A tailored intervention using the AIM2 project (Assessment, Intervention, Moving On) is then delivered. The project is designed to reduce the risk of further harmful sexual behaviours occurring or offences being committed. The project is delivered to young people and their families, where there are concerns about

problematic or harmful sexual behaviours, through the provision of advice, information, training and the development of practice frameworks and guidance. The AIM2 project assessments and related interventions can also be provided to young people who have not been sentenced in a court but only with an agreement between Social Care and the YOT. Over the last 2 financial years the YOT have supported 4 Thurrock young people who have committed sexual offences.

*Prison-based support*

It is likely that the majority of Thurrock's male prisoners would go to Chelmsford Prison, whilst an absence of a female prison locally means the female prisoners are most likely to go to Peterborough Prison. The support available to those who are convicted and imprisoned for committing sexual offences currently remains unknown.

*Police community-based support*

Essex Police currently deliver interventions in the community for offenders who have committed sexual offences. These are accredited programmes; Horizon and iHorizon. iHorizon is only available to those who have committed 'internet only' offences, currently or in the past. These programmes aim to help individuals manage unhelpful feelings and unhelpful sexual thoughts and behaviours, strengthen 'New Me' healthy thoughts and behaviours relating to sex and to develop a positive self-identity with the hope of reducing the likelihood of reoffending. The programmes are designed using the Bio-Psycho-Social Model of Change and Desistance Theory. We are currently unable to ascertain how many Thurrock residents have accessed these programmes.

## 5.3 Identification of gaps

The above has allowed the following gaps to be identified:

- Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34) however locally there is an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours

- Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remit of that mentioned above

- The majority of prevention programmes (e.g. the Good Man) are tailored towards and delivered to males. Whilst the Police data tells us that males make up 91% of known suspects of sexual offences locally, it is recognised that prevention programmes should also be delivered to females who are displaying harmful sexual behaviours.

## 5.4 Recommendations

Recommendations to address the local approach to prevention of sexual violence and abuse and those aimed at targeting perpetrators are included below:

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations around the prevention of SVA** | | |
| Local approaches to prevention of SVA are predominately school-based | The Thurrock Sexual Violence & Abuse Stakeholder Partnership should identify other options and channels to communicate prevention messages regarding so that a population based approach can be achieved. Messages should also be adapted to particular population groups where appropriate (e.g. those at high risk of SVA). | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| Existing school based prevention activity is inconsistent and often focuses only on particular year groups. There are opportunities to strengthen school-based approaches to prevention activities. | Schools, Academies and Thurrock Council's Education and Skills Department should capitalise on the opportunities presented by the Department of Education's mandatory requirement for the delivery of Relationships Education in Primary Schools and Relationships and Sex Education in Secondary Schools from September 2020 to ensure that knowledge of SVA and services available to support survivors is embedded and consistently covered within the curriculum. | Thurrock Council's Education Department, Head teachers, PSHE Leads, Safeguarding Leads etc. |
| | Proactive messaging on SVA and key topics such as consent, grooming and CSE should be consistently delivered to all age groups and embedded into each school's wider pastoral offer. | Thurrock Council's Education and Skills Department, Head teachers, PSHE Leads, Safeguarding Leads etc. |
| **Recommendations around targeting suspected perpetrators** | | |
| Local Police data tells us that the majority of SVA crime victims and suspected perpetrators are young (25% aged 0-17 and 42% aged 18-34). However, locally there is | *See recommendations above regarding approaches to the prevention of SVA (5.4)* | |
| | Thurrock's LSCP should develop a training proposal to ensure the wider children and young person's workforce (e.g. social workers, teachers, youth workers, School Wellbeing Service) are trained and appropriately supported to identify and screen for concerns linked to harmful sexual behaviours and/or sexual violence and abuse. | Thurrock Local Safeguarding Children Partnership (LSCP) |

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| an absence of programmes targeted specifically towards those in this age group who are displaying harmful sexual behaviours | Thurrock's LSCP should specifically include actions to address the issue of young suspected perpetrators within their relevant policies and action plans. | Thurrock Local Safeguarding Children Partnership (LSCP) |
| | Thurrock SVA Stakeholder Partnership should review and assess the appropriateness of existing provision designed for young people who are displaying harmful sexual behaviours to ensure an effective offer is in place locally. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | Thurrock's LSCP and NHS Thurrock Clinical Commissioning Group should ensure the Guidance from the National Institute for Health and Care Excellence (NICE) regarding harmful sexual behaviour among children and young people (NG55) is adopted and successfully implemented locally. | Thurrock Local Safeguarding Children Partnership (LSCP) |
| | Thurrock SVA Stakeholder Partnership should review the findings of the Learning and Development Group of Southend's Safeguarding Children's Board who have recently reviewed Harmful Sexual Behaviours in order to knowledge and best practice county- wide and implement changes locally where appropriate. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| Locally, there is an absence of programmes targeted specifically to those displaying harmful sexual behaviours for those who are outside the age remits mentioned above | Thurrock SVA Stakeholder Partnership should conduct a review of the evidence base of relevant programmes and potential demand locally in order to identify a suitable programme. Funding is to be secured if applicable. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| Local Police data shows that 11% of suspected perpetrators | Essex Sexual Abuse Strategic Partnership should conduct a review of the offer of programmes to those who have been convicted of | Essex Sexual Abuse Strategic Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| (of SVA offences reported by Thurrock residents) were reported for committing more than one offence. We are currently unaware of how this compares to other areas/nationally | sexual violence and abuse crimes and create a sustainable behaviour change programme for perpetrators of SVA (to be informed by the Essex Sexual Abuse Strategic Partnership's Sexual Violence Strategy, due to be published late 2019). | |
| Local and national data and engagement with survivors shows that both children and adults experienced SVA in a domestic setting or had a close relationship to the perpetrator (e.g. partner, ex-partner family member) | Embed knowledge related to recognising SVA in domestic settings amongst front line professionals to increase confidence in recognising and reporting incidences of SVA. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |

# Chapter 6: Disclosure

## 6.1 National evidence around disclosure

Where a 'disclosure' of sexual violence of abuse is discussed, this should be taken to mean a victim/survivor telling any other person about their experience of sexual violence/abuse for the very first time, whether formally or informally. Disclosure is often the first step to recovery and/or justice for many victims/survivors. Most victims/survivors who chose to disclose do so in an attempt to gain support, assistance and/or justice. There is a decision-making process that precedes disclosure.[53] Firstly, victims/survivors evaluate the nature of the incident/abuse to determine whether they have been victimised. Secondly, they weigh the pros, cons and anticipated reactions of disclosure and if the perceived benefits outweigh the costs, disclosure is more likely. Survivors are more likely to disclose if they feel it would be personally beneficial e.g. to help them feel better, provide them with access to support or if it would deter future crimes. Victims/survivors are less likely to disclose if they feel it would result in negative consequences such as not being believed, blame, shame and inappropriate responses from those who they have disclosed to.

Non-disclosure or delayed disclosure can prolong or even exacerbate the impacts of sexual victimisation. Despite this, 83% of victims do not report their experiences to the police.[54] For those who choose to disclose, whether it be planned or unplanned, it can take many years, particularly those who have been sexually assaulted or abused as a child or have a disability, with research showing the average time taken for victims/survivors to disclose childhood sexual abuse is 26 years.[55]

Findings from the 2017 Crime Survey for England and Wales (CSEW) regarding disclosure are demonstrated in Figure 11 below.

*Figure 11: Crime Survey for England and Wales findings[56]*


## 6.2 Barriers to disclosure

There are a number of internal barriers to disclosing sexual violence and abuse, with the most commonly reported summarised in Figure 12 below. Beyond an inability to label an experience, a lack of knowledge limits understanding of the nature of the consequences of an assault or abuse and so harmful feelings of guilt, shame and loss of control can fester.

A key barrier is lack of knowledge regarding sexual violence and abuse itself. It is to be noted that there is generally a lack of awareness regarding what causes and constitutes sexual violence and abuse, common impacts of victimisation, and coping skills and available resources. The ability to recognise an experience of SVA is essential to seeking help. Without knowing how an experience of violence might affect them, some victims/survivors may not feel that they need to seek help if they were not physically harmed.[57]

*Figure 12: Barriers to disclosure*[58, 59]


## 6.3 Professional responsibilities following disclosure

Where there has been a disclosure, report or concern of sexual violence, the professional should make an immediate risk and needs assessment which should be considered on a case-by-case basis. The risk and needs assessment should consider the victim/survivor (their capacity to consent, their immediate and future protection and support), the alleged perpetrator and any other individuals who may be at risk of sexual violence/abuse. Where a child has been harmed, is at risk of harm, or is in immediate danger a safeguarding referral should be made to local Children's Social Care. A referral to Social Care may not require in instances where the harm is in the past and is no longer present.

No child under the age of 13 can ever consent to any sexual activity and therefore under-13s are given additional protections in law due to their age and vulnerability.[60] Circumstances concerning suspected or reported sexual violence/abuse involving a child or young person under the age of 13 should result in an automatic referral to the Police and Children's Social Care. Generally, parents or carers will be informed for children under the age of 16 (the legal age for consent) unless there are compelling reasons not to, for example, informing the parent/carer is going to put the child/young person at additional risk. Local engagement with professionals and findings from the

REAL. conference identified varying levels of knowledge regarding the safeguarding processes required post-disclosure (see section 6.7.3 for further information).

## 6.4 Importance of a positive reaction

It is imperative that all disclosures are met with the sensitivity and support required. Supportive responses can reaffirm self-worth and improve psychological and physical wellbeing.[61] Unfortunately disclosures do not always produce supportive responses or the response desired by the victim/survivor. Poor reactions include those that are judgmental, blame and shame the victim/survivor and/or provide incorrect and poor information based on myths of sexual violence and abuse. Such responses can have a detrimental impact on recovery and may result in negative outcomes such as feelings of shame and isolation, an increased likelihood of the victim/survivor experiencing additional psychological trauma, not accessing appropriate support and becoming withdrawn or isolated.[62]

## 6.5 Thurrock data on disclosure

Modelling the disclosure information from the Crime Survey for England and Wales to our estimated numbers of SVA survivors in Thurrock would give the following (*note that victims may have told more than one person so could be counted in more than one of the latter categories*):

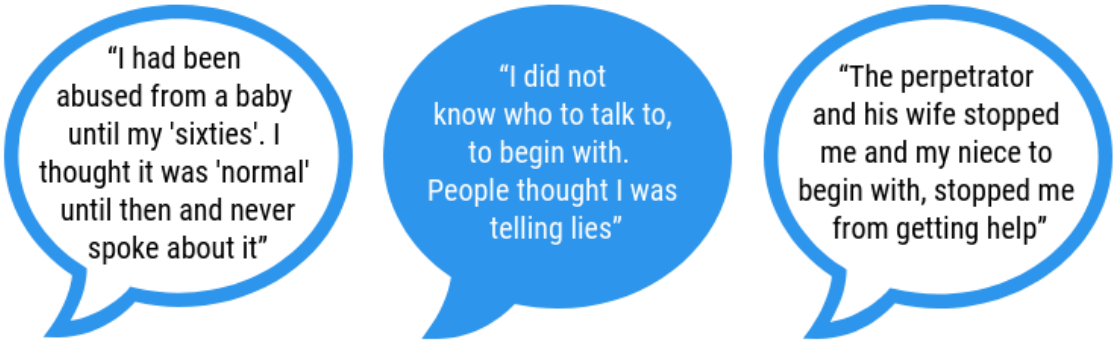
| CSEW finding | Estimated number of Thurrock victims (within the last year aged 16-59) | Estimated number of Thurrock victims (ever experienced abuse aged 16-59) |
|---|---|---|
| **31% victims told no one of their most recent experience** | 609 | 3,751 |
| **58% victims told someone close to them** | 1,140 | 7,019 |
| **30% victims told a professional** | 590 | 3,630 |
| **17% victims told the police** | 335 | 2,057 |

Local engagement with survivors identified the following key points regarding survivors' experiences of disclosure:

- Survivors reported that disclosures had most commonly been made to their family and friends
- Whilst many survivors disclosed within 3 months of the abuse having occurred, one third of respondents said they disclosed over 2 years later.
- The most common responses to disclosures centred around onward referrals, provision of direct support (if the disclosure was to an agency), listening, or following specific processes.

## 6.6 Local engagement with survivors regarding barriers

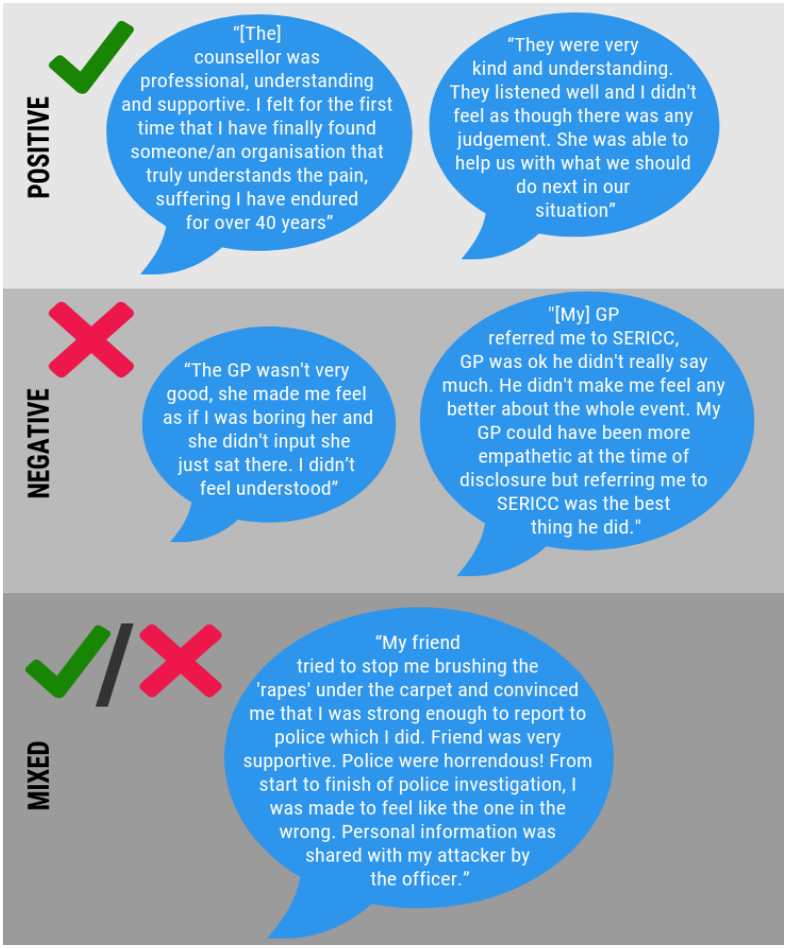
Local survivor's thoughts and experiences related to barriers to disclosure were predominately discussed during the interviews. Key barriers mentioned included; embarrassment, guilt, feeling ashamed, not wanting to be judged by others, a low conviction rate of perpetrators and a lack of confidence in future action. Examples are included below:




## 6.7 Experience of reaction to disclosure

### 6.7.1 Engagement with survivors

Local engagement with survivors has identified that victims/survivors want to be asked what their preferred options were and they want to be informed of the processes that must or could happen post-disclosure. Survivors spoke of how their disclosures were responded to in varied ways, which also varied dependent on who they initially disclosed to. Positive experiences of disclosure included those which made the survivor feel listened, supported and resulted in positive outcomes such as onward referral to support services. Negative experiences of disclosure included those which were judgemental and lacked consideration for the feelings of the survivor, e.g. sharing information with people where not necessary. Quotes from local survivors are included below:



The video below provides accounts of the experiences of local survivor's experiences of disclosure.

### 6.7.2 Engagement with professionals

*Professionals' awareness of services*

Engagement with local professionals identified that generally there is a good level of awareness of the services available in Thurrock to support victims/survivors. Respondents were asked to name support services that they were aware of (more than one could be listed). Specialist support was reasonably well known by respondents. Non-specialist sexual violence and abuse services that may also provide services to survivors (e.g. Mental Health GP, A&E and Social Care) were only mentioned by a small number of individuals.

*Professionals' responses of actions following a disclosure*

When asked about actions that were taken following a disclosure of sexual violence and abuse, common responses included; referral to SERICC/specialist sexual violence service, to follow safeguarding processes and to inform of support services available. It is to be noted that asking the victim/survivor what they wanted was only the tenth most common response given. Respondents were then asked exactly where they would signpost survivors towards if they were unable to support them further. SERICC was the most commonly response, provided by 56.3% of respondents. The police and GP/nurse were the next most common. It is unclear if those reporting 'counselling/talking therapies' meant specialist counselling or generic counselling.

### 6.7.3 The REAL. Conference

*Respect. Empathy. Awareness. Listen. A full stop to represent ending the silence.*

On 2nd April 2019 a group of ten young victims/survivors who have accessed sexual violence and support from SERICC delivered a powerful conferenced aimed at raising awareness of sexual violence amongst professionals. Key focuses of the conference were how disclosures should be handled and the information sharing processes that follow. Throughout the day a series of four group sessions were delivered, each focussing on the importance of the four key requirements for disclosure, as identified in the title; Respect, Empathy, Awareness and Listening. The young people clearly and innovatively demonstrated how a poorly handled disclosure translates into a loss of control of the situation and can be just as traumatic as the incident(s) of sexual violence and abuse that victims/survivors have experienced.

Through the group sessions, the young people clearly demonstrated how a disclosure to one person could quickly result in up to 15 different professionals/ friends/ family knowing about the incident(s). This is often a professionals desire to safeguard young people and an assumption that the more people that know, the better than young person can be safeguarded and cared for. This often left young people with no control over their situation and a sense of feeling powerless, adding to the feeling of not having control that will have formed a part of their rape/assault/abuse. Instead, young people expressed the need for the process to be slowed down, with professionals taking the

time to think about who actually does need to be informed within the laws that surround child protection as opposed to the default mode of informing everyone connected to that young person.

The conference also highlighted that amongst the professionals in attendance there was a misconception that every case had to be reported to the Police, however in fact this is not true for young people aged over 13 years old and are Fraser/ Gillick competent to make that decision. That choice should therefore lie with the young person and should only be breached should that young person be in immediate danger of further threat or harm. Another key theme was that young people wanted to be consulted where this happened to give them back control.

Following on from the conference the Local Authorities Children's Commissioner has compiled a 'step by step' guide detailing how professionals should respond appropriately to disclosures of SVA by children and young people.

### 6.7.4 Challenging Myths, Changing Attitudes Training

Locally, efforts have already been started to improve professional's understanding of SVA and appropriate actions following disclosure. In 2018 SERICC delivered a bespoke training course to over 200 professionals from a range of organisations in Thurrock. This course requested and commissioned by Thurrock Community Safety Partnership in order to enable professionals to understand sexual violence and abuse and the potential impacts of SVA on the victim/survivor and their friends/family/partner. The training also sought to help professionals feel confident to challenge commonly held myths around SVA, to build their skills and confidence in order to enable them to provide effective responses to disclosure. The training was also an opportunity to raise awareness of the relevant services available locally.

## 6.8 Recommendations to address barriers and poor response to disclosure

It is recognised that locally, we must improve our responses to disclosure in order to ensure that victims/survivors are treated respectfully and with dignity and are provided with correct information and prompt access to appropriate services when they require them.

The following recommendations are suggested in order to improve responses to disclosure locally:

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations for improving responses to disclosure** | | |
| Locally, survivors report a lack willingness to disclose their experience of SVA to anybody (including formal and informal sources). A number of factors are known to deter disclosures and willingness to seek support. Local engagement tells us that these factors include lack of confidence to access services, fear of not being believed and a low perpetrator conviction rate | Thurrock SVA Stakeholder Partnership should implement a coordinated programme of communications activities to be delivered to the public, to include; reducing the stigma of SVA, tackling social myths and stereotypes in order to increase public confidence in reporting crimes and seeking appropriate support | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| Locally, disclosures are more commonly being made to informal sources (i.e. family and friends) rather than to professionals. This may result in disclosures not being handled appropriately and/or survivors not being aware of the relevant services and support available | Thurrock SVA Stakeholder Partnership should review suitable training programmes (whether existing or bespoke) that can be delivered in order to support informal sources respond appropriately to disclosures. Examples may include the Thurrock Community Safety Partnership's (CSP) Challenging Myths Changing Attitudes training, or a variant of the J9 Domestic Abuse Awareness training tailored towards SVA. These should be delivered consistently across Thurrock, including to families/friends where requested. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| Locally, not all responses to disclosure, whether to formal or informal sources, have been handled appropriately and sensitively, which can be extremely traumatic to the survivor.<br><br>Survivors often reported that professionals in a rush to follow organisational protocol and 'cover their own back' disclosed information to multiple additional professionals leaving the survivor feeling that 'they had lost control of the process' | Thurrock Council Education and Skills Department in partnership with local schools and Academies should audit all school policies on SVA disclosure to ensure a consistent approach based on best practice that keeps the needs of the survivor at the centre of the process | Thurrock Council Education and Skills Department<br><br>Head Teachers and Academy Chief Executives |
| | Thurrock SVA Stakeholder Partnership should commission a coordinated programme of training/communications activities to be delivered to professionals and informal sources, to include; reducing the stigma of SVA, tackling social myths and stereotypes, in order to improve responses to disclosure. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| Some professionals surveyed said that they did not feel confident dealing with disclosures, with many professionals requesting further training in this area | Thurrock SVA Stakeholder Partnership should develop a bespoke toolkit for professional use in order to facilitate appropriate responses to disclosure. This toolkit should be issued to all appropriate frontline professionals in Thurrock. The toolkit should be used to supplement training and provide information including safeguarding requirements, appropriate language, local service provision and referral pathways. | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| | Thurrock SVA Stakeholder Partnership should conduct a full evaluation of training possibilities, seeking input from staff/management within key organisations, in order to determine which are most effective in increasing professionals' confidence responding to disclosures. This training should be then made available to professionals in order to ensure they are appropriately informed, skilled and confident in handling disclosures. | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| | A toolkit to be developed and issued to all frontline professionals in Thurrock in order to improve ongoing confidence during and following disclosure and ensure survivors are informed of options for support.<br>This toolkit should:<br>- Include information regarding conducting risk/needs assessments for survivors, as per relevant safeguarding processes<br>- Contain information including operational protocols, safeguarding policies, practical skills and information regarding service provision and referral pathways<br>- Provide professionals with a clear understanding of how to respond appropriately to disclosures, including the actions that should follow<br>- Incorporate the findings of this needs assessment and the Thurrock REAL. Conference<br>- Seek input from specialist SVA services<br>- Be coordinated by the new Thurrock Sexual Violence and Abuse Stakeholder Partnership to oversee the development and support implementation (see recommendation in chapter 11) | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| Some survivors reported that their disclosures/information related to their SVA was shared with more people than they felt was necessary. Following disclosure, 68% of local survivors relied on professionals giving them further information/ signposting towards seeking specialist help themselves rather than a referral being made on their behalf. Whilst SERICC appear to be well-known in the borough, the process would be smoother and may result in better outcomes if survivors were referred directly using appropriate mechanisms | The toolkit and training as mentioned above should address this issue through providing professionals with a clear understanding of the processes following disclosure including what information should be shared and with who | Thurrock Sexual Violence and Abuse Stakeholder Partnership supported by Safeguarding Leads and Specialist SVA Services |
| | Referral pathways and processes into specialist SVA services must be developed, agreed with key stakeholders and used by all referring organisations | Thurrock Sexual Violence and Abuse Stakeholder Partnership |
| | Organisations to network more effectively so that they better understand each other's service offer for survivors, and to be directed to make referrals in to specialist support services as opposed to signposting.<br><br>Thurrock Public Health Service to organise a conference for all local stakeholders to launch this Joint Strategic Needs Assessment product and commence discussion between stakeholders | All providers of services that may support SVA survivors, to be identified and facilitated by the Thurrock Sexual Violence and Abuse Stakeholder Partnership<br><br>Thurrock Council Public Health Service |

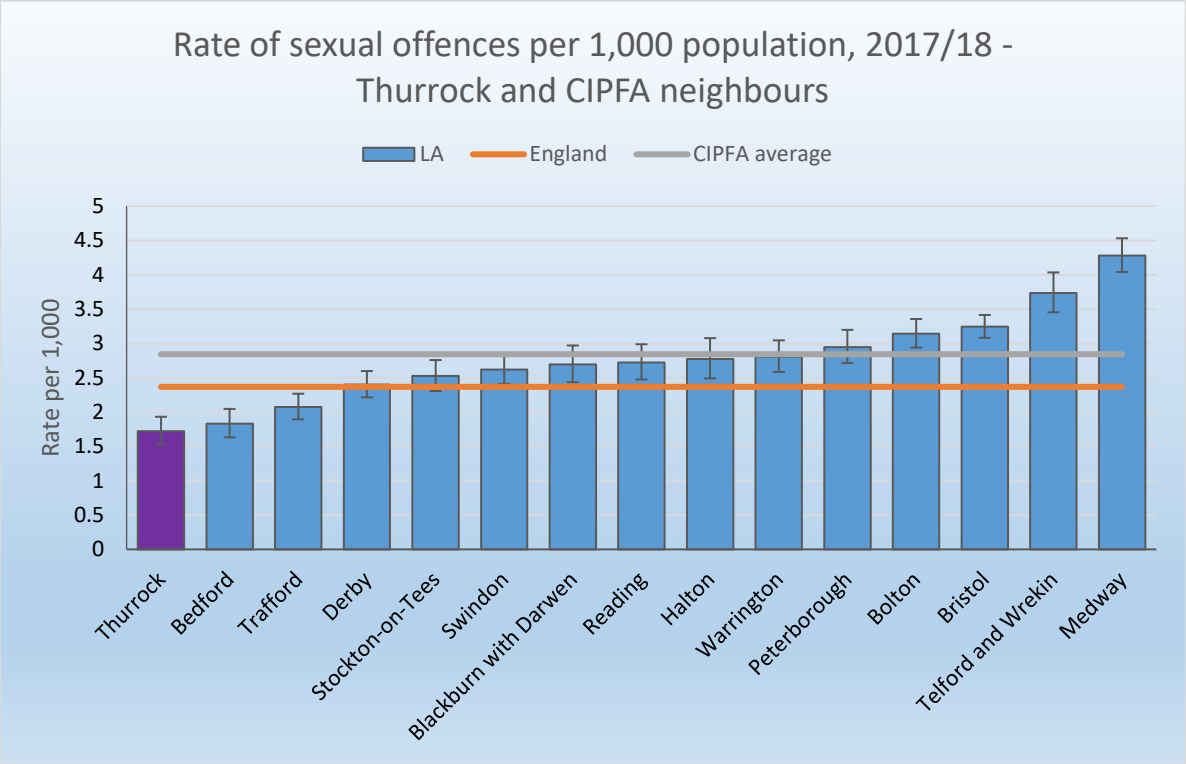
| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| | Where practicable, referral forms to SVA support services should be automated or embedded into organisational information systems (e.g. the Systm One or EMIS systems in General Practice and hospital systems) | Thurrock Sexual Violence and Abuse Stakeholder Partnership |

# Chapter 7: Criminal Justice for victims/survivors

## 7.1 Comparison of SVA crime with other areas

Thurrock has a reported sexual offence rate of 1.7 per 1,000 population. This is a crude rate per 1,000 population including crimes of all ages and sexes that have been reported to the Police. The Thurrock rate is significantly lower than the England average of 2.4 per 1,000. When compared to our most similar local authority areas as defined by CIPFA (Chartered Institute of Public Finance and Accountancy), Thurrock ranks the lowest, whereas Medway has the highest rate of 2.8 per 1,000. It is to be noted that this only includes incidents reported to the Police. Incidents that were not reported to the police and incidents that the Police decided not to record are not included.

*Figure 13: Rate of sexual offences- Thurrock compared to CIPFA comparators*




Source: Home Office and Public Health England

The above chart tells us that Thurrock has a lower rate of reported sexual offences per population head when compared to other areas. But it doesn't tell us how this relates to the likely expected prevalence, or expected number of offences that actually took place. These are modelled in section 7.4 below.

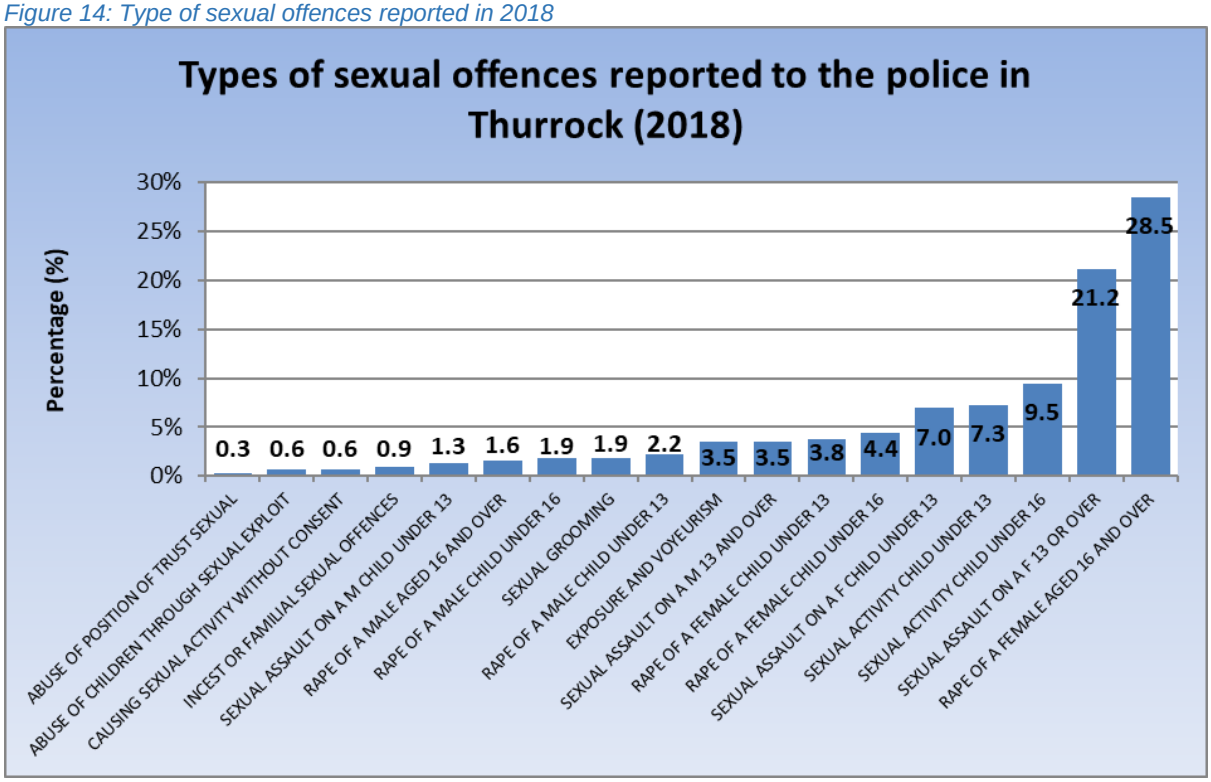
## 7.2 Sexual Violence & Abuse in Thurrock reported to Essex Police

The following includes information related to the sexual offences reported and is therefore only likely to be a small proportion of all sexual offences actually committed. In 2018, **316** victims of reported sexual offences were recorded in Thurrock. This compares with 297 in 2017, an increase of 6.4% in one year; this increase is larger than expected considering a population increase in that same time of 1.2%.

### 7.2.1 Type of crime

Victims of reported rape or attempted rape accounted for 42% of total victims of sexual offences in Thurrock, compared with 35.8% of total offences nationally. Of the 316 recorded sexual offences in Thurrock in 2018, the most commonly reported (90) was 'rape of a female aged 16 and over'.

*Figure 14: Type of sexual offences reported in 2018*



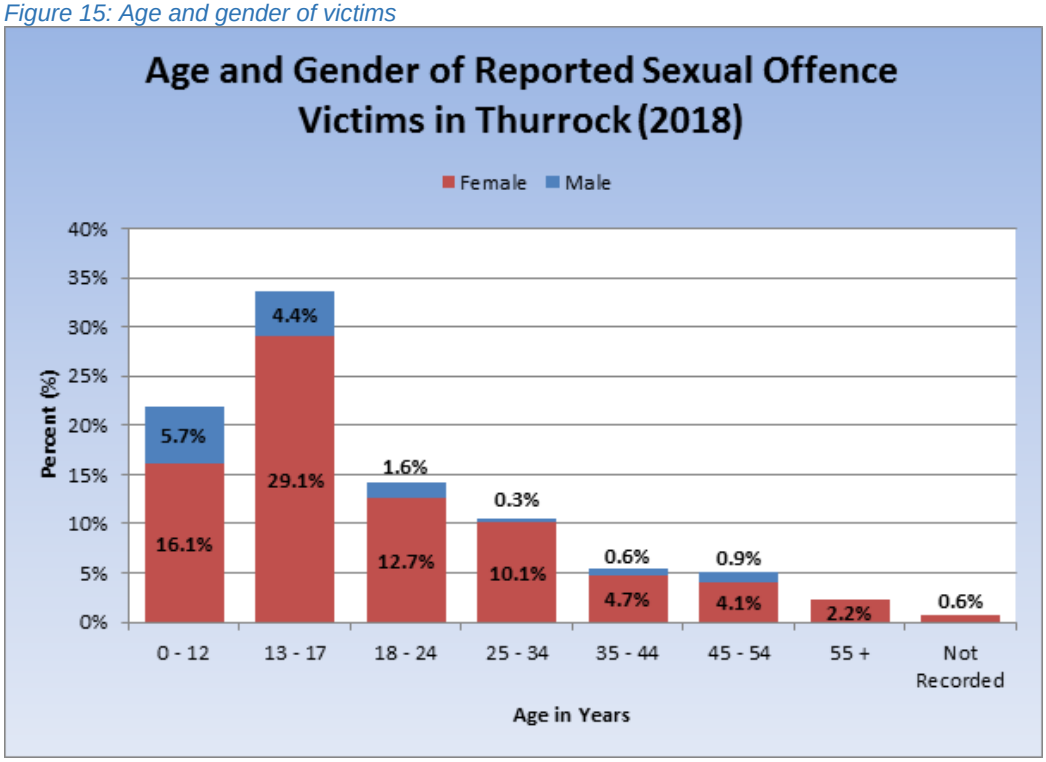

### 7.2.2 Sexual offences linked to Domestic Violence

Domestic violence (DV) related offences account for 57 (18%) of these offences, of which 19 were of high risk and 19 medium. Where a DV marker was 'Not Recorded', this indicates that **there was no domestic abuse reported, or that** the risk level was not entered into the box where it would be expected. It is noted that DV markers were included for approximately 50% of incidents within the 25-34, 35-44 and 55-64 age groups. DV markers were also noted in 10% of the sexual offences in the 13-17 year age group. Given the strong links explained in chapter 4 regarding domestic violence and sexual violence and abuse, it is expected that this is an under representation of the true extent.

### 7.2.3 Victims' Demographics

The majority of victims of reported sexual offences in 2018, where gender is recorded, were women (79.7%), and for men 13.6%; for rape offences the percentage of female victims rises to 87%. The highest proportion of victims are in the 13-17 age range, followed by 0-12 years; From 17 years old, reported sexual offences tail off as age increases.

*Figure 15: Age and gender of victims*




The largest proportion of victims described themselves as 'White' 54%, with 7% from Black, Asian and Mixed self-defined headings. Self-defined ethnicity was not recorded or not stated for 39% of victims; this makes comparison to the wider Thurrock population not possible.

### 7.2.4 Location

Whilst this data reflects crimes committed within the Thurrock area, 9% of victims lived elsewhere in Essex (not Thurrock) and the largest proportion, 23.7%, didn't live in Essex at all. While we cannot establish all the reasons a non-Thurrock resident was victimised within Thurrock, some common reasons include:

a) The victim is reporting an historic offence that occurred in Thurrock, the precise address of the victim at the time of the offence could not be established at the time of the recording so their current address at time of reporting has been recorded.

b) The victim was visiting the offender in Thurrock – a friend, partner, date, relative or other associate.

c) The offence occurred online (social media or other platforms) with the identified suspect in Thurrock and the victim living elsewhere.

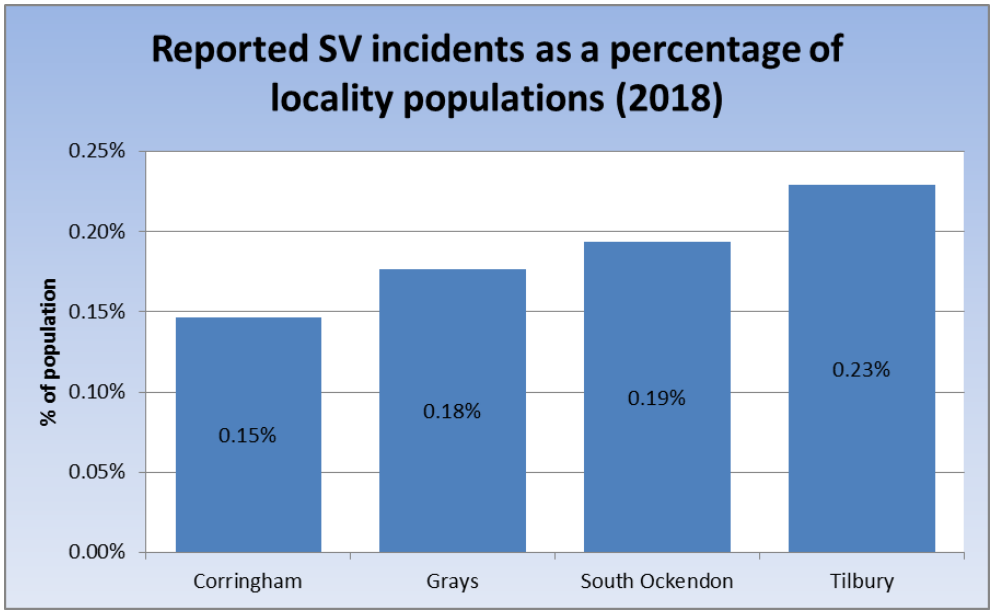
d) The victim and offender met elsewhere and the suspect has then taken them into Thurrock on the day of the offence. This may be to a dwelling, hotel or business premises.

e) The victim was attending a party, shopping centre or visiting friends (not including the suspect).

f) The victim was attending an educational establishment or business.

For the 67.3% of victims that lived in Thurrock, the chart below shows the location of reported SV incidents as a percentage of locality populations. The range of proportions (0.15%-0.23%) is not wide despite the considerable difference in population size between the localities. This indicates that there are slightly more reported incidents per head in Tilbury and fewer reported per head of population in Corringham.

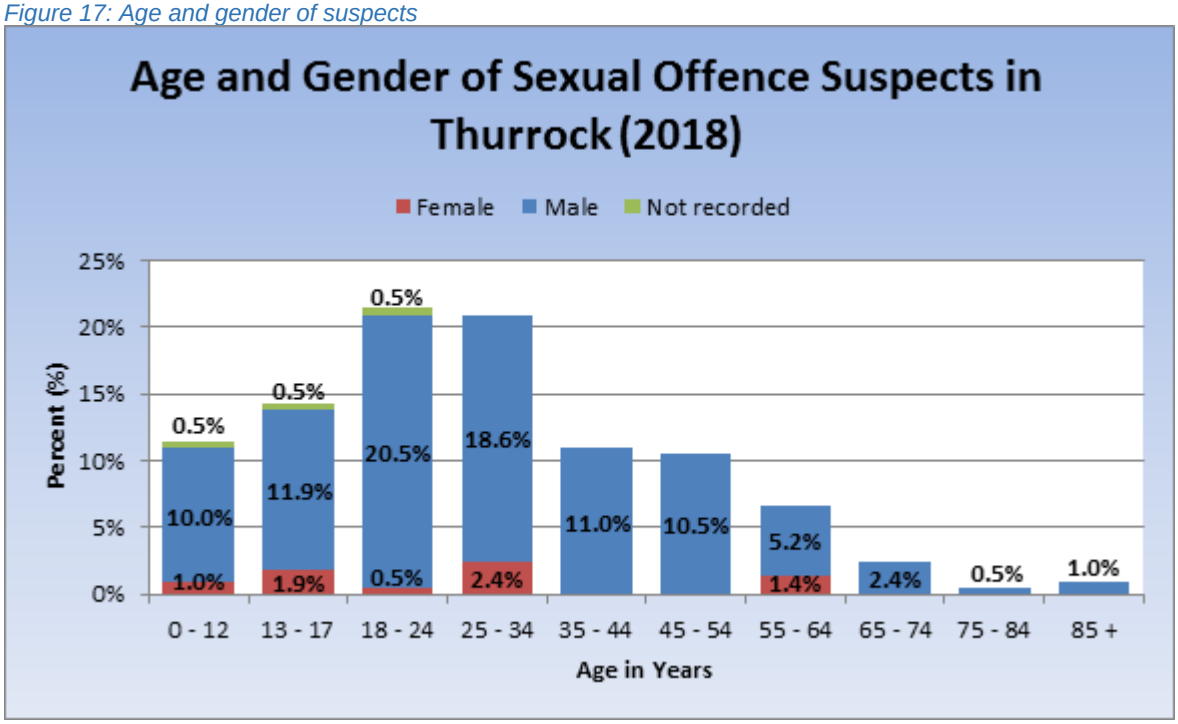
*Figure 16: Locality of crimes*




### 7.2.5 Suspects' Demographics

The chart below displays the demographics of suspected perpetrators of sexual offences in Thurrock in cases where a suspect is known to the police. The vast majority (91%) of suspected perpetrators are male, which is a higher proportion than seen in national data from the Crime Survey for England and Wales which shows a male perpetration proportion of 74-79% for sexual offences. Suspected perpetrators tend to be younger men with peaks occurring in the 18-34 age range (42%). The next largest group of suspects is 13-17 years (14%) followed by 0-12 years (11%); 5.7% were under the age of criminal responsibility (10yrs). Suspects tail off as age increases with very few being aged over 65years. The data collected on suspects' ethnicity was not of sufficient quality for conclusions to be drawn; 33% of suspects had their ethnicity listed as '*Not stated'*, *'Not recorded'* or *'Other'*.

*Figure 17: Age and gender of suspects*




### 7.2.6 Repeat offences

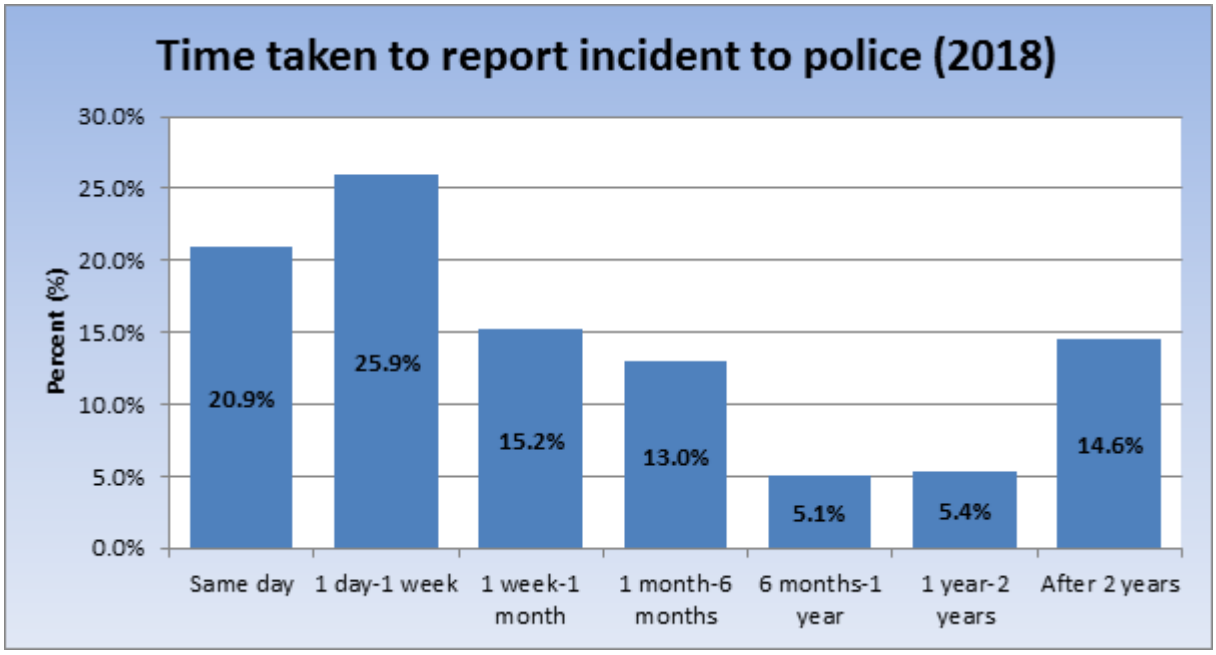
The majority (92%) of victims have reported a single incident whilst the remaining 8% have reported multiple incidents. Multiple offences may have been committed by the same or multiple different perpetrators.

The majority (89%) of suspected perpetrators have been reported for a single sexual offence while only 2% are suspected serial offenders (3 or more offences). Multiple offences may have been against the same or multiple different victims however it is not possible to determine the extent to which this occurs.

### 7.2.7 Time taken to report/record

The following diagram shows how long after the incident the crime is reported for those victims of sexual offences in Thurrock during 2018. 47% reported within a week and 21% the same day, 15% reported two or more years after the offence. It is to be noted that the *'two or more years' category will include victims who have disclosed ten, twenty plus years after the offence took place.*

*Figure 18: Time taken to report to the Police*




### 7.2.8 Outcomes of police reported crime

The largest proportion of outcomes in 2018 was 'Not Recorded (not yet finalised)' at 28%; 24% did not support action and 13.6% are recorded as '*Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action*'. All of the top three recorded outcomes involve '*evidential difficulties*'. Type 20 outcomes (Further action to be taken by another body) are overwhelmingly made up of crimes in which the victim is aged 0-17 years. The proportional relationship between type of crime and type of outcome is very similar to the proportion of overall outcomes displayed in the table below.

Sexual crimes from 2017 have fewer outcomes recorded as '*Not yet finalised*' (as this refers to crimes still subject to ongoing investigations) than those in 2018; however, 'Type 15: *Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action'* was significantly higher in 2017 than 2018. The data available does not give insight into prosecutions, *Type 1: Charged/Summonsed/Postal Requisition* is the furthest stage available; 5.1% of incidents reached this point in 2017 and 4.4% reached it in 2018.

*Figure 19: Incident outcomes of SVA reported crimes*

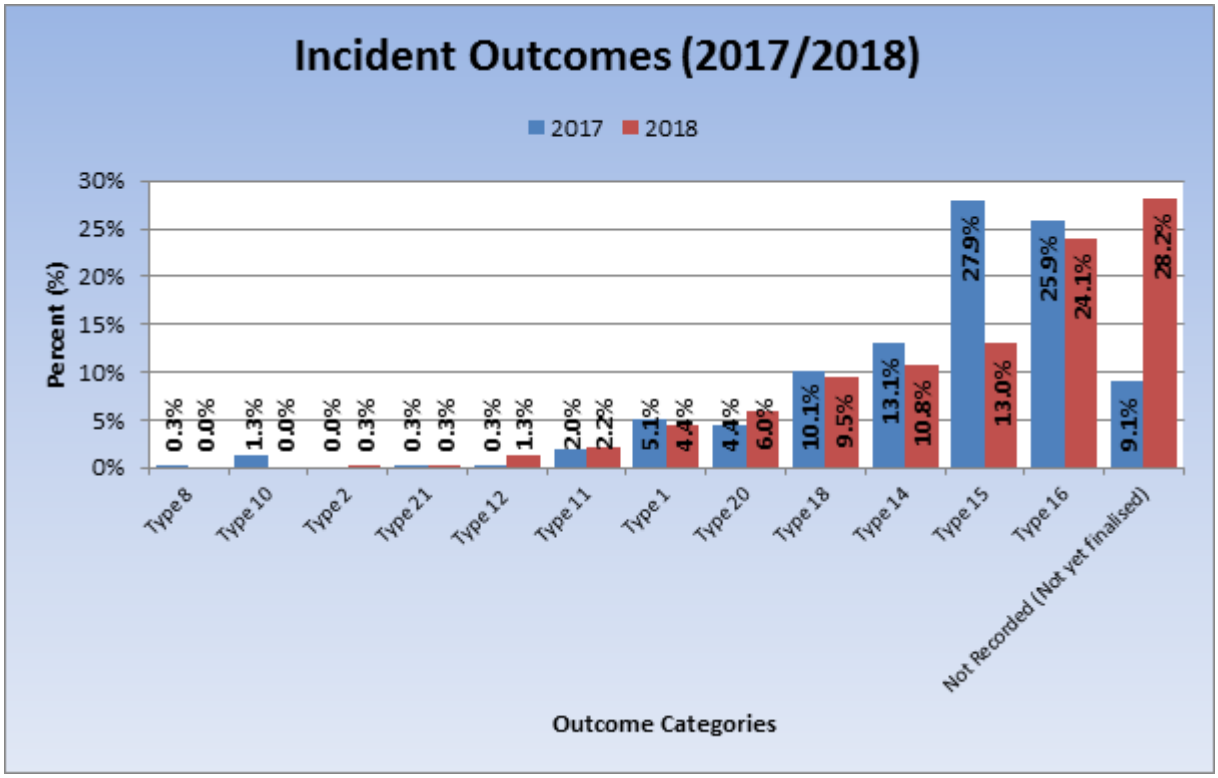


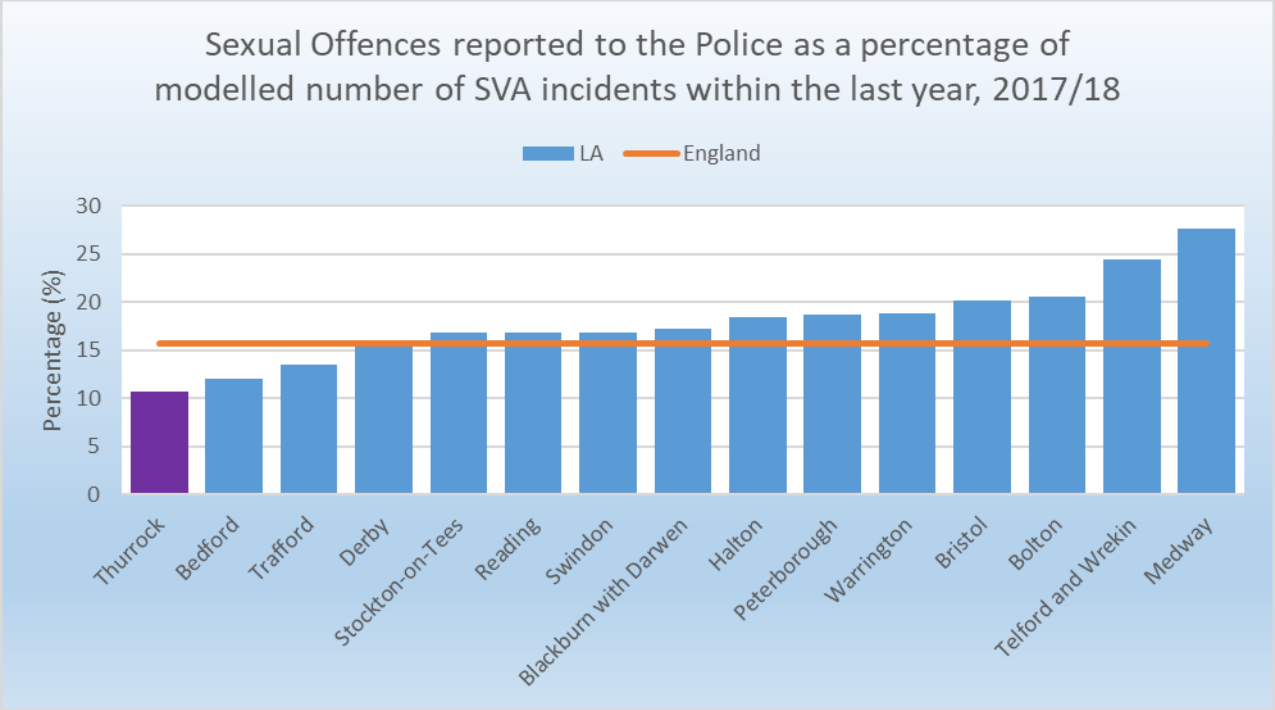

*Figure 20: Definitions of outcome categories*

- Type 8: *Community resolution (Crime)* *restorative justice
- Type 10: *Formal Action against Offender is not in the Public Interest (Police)*
- Type 2: *Caution Youth*
- Type 21: *Further investigation resulting from crime report which could provide evidence sufficient to support formal action against the suspect is not in the public interest - police decision.*
- Type 12: *Prosecution Prevented-Named Suspect Identified But Is Too Ill (Physical Or Mental Health) To Prosecute*
- Type 11: *Prosecution Prevented-Named Suspect Identified But Is Below The Age Of Criminal Responsibility*
- Type 1: *Charged/Summonsed/Postal Requisition*
- Type 20: *Further action resulting from the crime report will be undertaken by another body or agency subject to the victim (or person acting on their behalf) being made aware of the act to be taken*
- Type 18: *Investigation Complete; No Suspect Identified. Crime Investigated As Far As Reasonably Possible-Case Closed Pending Further Investigative Opportunities Becoming Available*
- Type 14: *Evidential Difficulties Victim Based- Suspect Not Identified: Crime Confirmed But The Victim Either Declines Or Unable To Support Further Police Investigation To Identify The Offender*
- Type 15: *Named Suspect Identified: Victim Supports Police Action But Evidential Difficulties Prevent Further Action*
- Type 16: *Named Suspect Identified: Evidential Difficulties Prevent Further Action: Victim Does Not Support (Or Has Withdrawn Support From) Police Action*

## 7.3 Comparison to estimated number of survivors

Applying the same methodology as described in section 7.1 to the other comparator areas, enables us to see that Thurrock is reporting the lowest proportion of its estimated number of offences (11%) compared to the national average (16%) and other comparable areas – Medway for example appears to be reporting 28% of SVA offences to the Police.

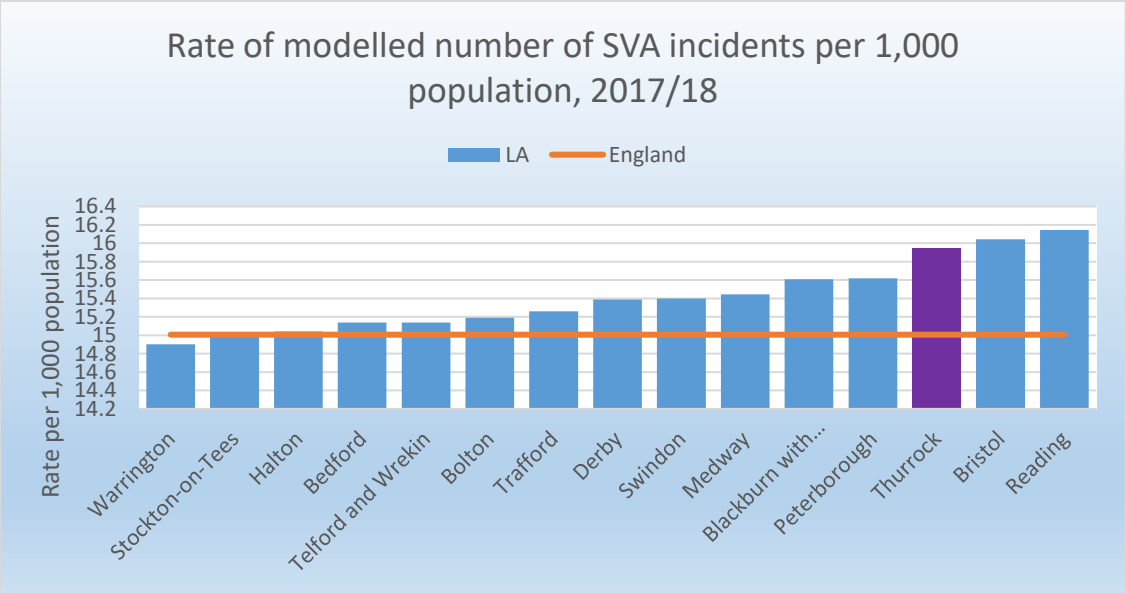
*Figure 21: Sexual offences reported to the Police as a percentage of the modelled number of SVA incidents within the last year*




Source: Home Office, Office for National Statistics and CSEW

We can use the modelled estimated number of SVA incidents for each area to ascertain whether the actual level of need (reported or unreported) is different in Thurrock compared to other similar areas. The chart below shows the estimated number of incidents as a rate against the populations of each area, and it can be seen that Thurrock is likely to have a higher rate of SVA need per population head than other similar areas.

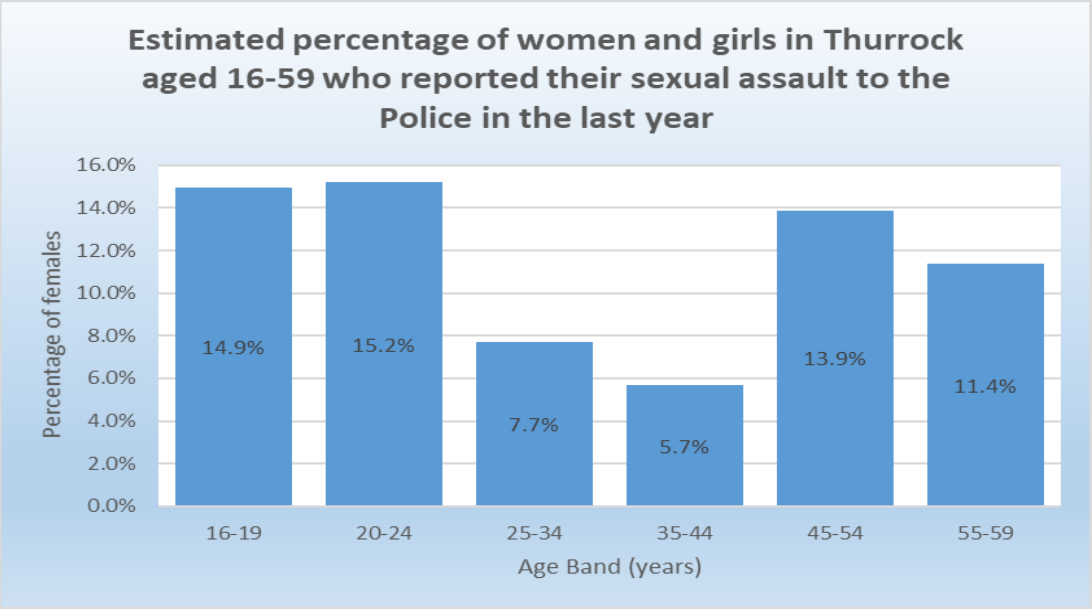
*Figure 22: Rate of modelled number of SVA incidents*




Source: Home Office, Office for National Statistics and CSEW

Taking the modelled prevalence estimates per age group (see section 3.2) and the number of reported crimes per age group (see section 0) for women and girls, it can be seen that this issue of under-reporting is even more prevalent in women aged 25-44 years, with the number of crimes reported by those aged 35-44 years equating to fewer than 6% of those estimated to have occurred. (This looked at comparing crimes by the age of the survivor when it was committed, against the modelled estimates of incidents for that age group). As shown in Figure 21, Thurrock's reporting rate across all ages and genders is around 11% of expected crimes, so although the below chart is just for females, it is expected to also be an issue for males.

*Figure 23: Estimated percentage of women and girls in Thurrock aged 16-59 who reported sexual assault to the police in the last year*




Source: VAWG Ready Reckoner and Essex Police data

### 7.3.1 Suspect Demographics

Of the suspects that are reported to the Police, Thurrock has a higher proportion of males suspected of SVA offences compared to nationally (91% vs 74-79%). The reason for this currently remains unknown however, may be attributable to a local underreporting of SVA crimes committed by females.

The data regarding suspect's demographics indicates that the majority tend to be younger men with peaks occurring in the 18-34 age range (42%). The next largest group of suspects is 13-17 years (14%) followed by 0-12 years (11%); 5.7% were under the age of criminal responsibility (10yrs). This highlights that there are young people in Thurrock displaying harmful sexual behaviours. When compared with the age of victims/survivors in Figure 15, this would suggest the likelihood of sexual offences being peer-on-peer.

### 7.3.2 Time taken to report to the Police

As demonstrated in section 7.2.7 Time taken to report/record locally the time taken report offences to the Police varied greatly. It is to be noted that whilst the Police data currently only reports offences in the category of 2+ years after the incident, these statistics vary greatly from national estimations which suggest that the time taken to disclose is 26 years[63].

### 7.3.3 Outcomes as a proportion of all estimated offences

The Police data shows that a very small proportion of reported sexual offences result in the suspect being charged, for example; 15 out of 297 offences in 2017 were charged at this point, a rate of **5%.** Looking at this against the number of offences estimated to have actually occurred within that year (2,718), this means that approximately **0.55%** of SVA offences in Thurrock in 2017 led to the suspect being charged; and this does not guarantee a conviction. Actions underway currently to address this can be seen in section 7.6 below.

## 7.4 User voice

Whilst this needs assessment did not specifically seek to obtain survivors thoughts and experiences of the Criminal Justice System, it is recognised that some of the negative consequences associated with reporting to the Police (e.g. fear of not being believed, fear of being questioned or examined and a local perpetrator conviction rate) may act as a deterrent. This was specifically mentioned by one of the survivors interviewed:

*"I just thought it wouldn't be in my best interest to report it because I didn't feel anything would happen… and I think possibly has well to do with the conviction rate of rapists and abusers…its low so then it automatically goes to…'well that person possibly wasn't found guilty, so, maybe she did choose to, have sex with that person… I didn't want to be judged by other people because, what I said before, the first question people ask is "was the person drinking, what was the person wearing, where were they, what time were they out" and I think that's the main reason that I didn't want to have to deal with those things as well."*

## 7.5 Measures taken locally to improve the criminal justice process for victims/survivors

As crime increases, Essex Police have seen the proportion solved fall. This is not specific to Essex and is seen across the country. A different way of thinking is required to reverse this trend. It is their priority that more offenders are brought to justice thus reducing the risk to further victims being harmed. In order to do this Essex Police are working with partners to improve the response to Victims of sexual offences monitored through their rape improvement plan. The Plan is a review of the Police's processes and procedures and the work to date has included introducing a dedicated team for historic child sexual abuse, work with victim support services to have better pathways to support and introduction of rape scrutiny panels. The Plan also focuses on bringing more offenders/perpetrators to justice. In order to do this Essex Police are working closely with the Crown Prosecution Service (CPS) to improve criminal justice outcomes for victims.

Project Goldcrest is an example of innovative practice that aims to address the issues of time taken to disclose and incident outcomes identified above. Project Goldcrest is a project led by Essex Police and developed with Thurrock Council and SARC to look at alternative ways to engage high risk young people who typically may not disclose or engage with services. This project is due to launch in the Autumn of 2019. Current procedure requires the young person to disclose the assault, provide police with an evidential account and for forensic evidence to be obtained for any action to be taken. Understandably, many young people will, for the reasons explained above, be reluctant to engage with statutory services. This results in the police being unable to

bring any perpetrators to justice and remove the risk to the child and others. For this small but high-risk cohort of children, we are proposing to remove the emphasis of providing an evidential account and allowing them a choice about how forensic evidence is obtained which can be stored securely and anonymously until a point in the future where they feel able to disclose. Using this anonymous intelligence, Police can begin to proactively disrupt perpetrators without the need for the young person to be identified, putting themselves at further risk from the perpetrator.

## 7.6 Recommendations to address

The following recommendations are made in order to improve the reporting of offences locally:

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations for those in the reporting of crimes to the Police** | | |
| Thurrock has lower levels of reporting SVA offences to the Police than other similar areas, and of those that are reported, there is a very low proportion that lead to the suspect being charged. There is variation by age group in terms of the proportion of women estimated to have experienced SVA who have reported it to the Police, particularly seen in women aged 25-44 years (the rate is between 6-8%) | Ensure Project Goldcrest is evaluated in order to determine whether it is effective in encouraging survivors to participate in forensic evidence gathering and supporting the Police with prosecuting perpetrators. | Essex Sexual Abuse Strategic Partnership |
| | Communications activity as previously recommended should seek to target women in this age group to increase confidence in reporting. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |

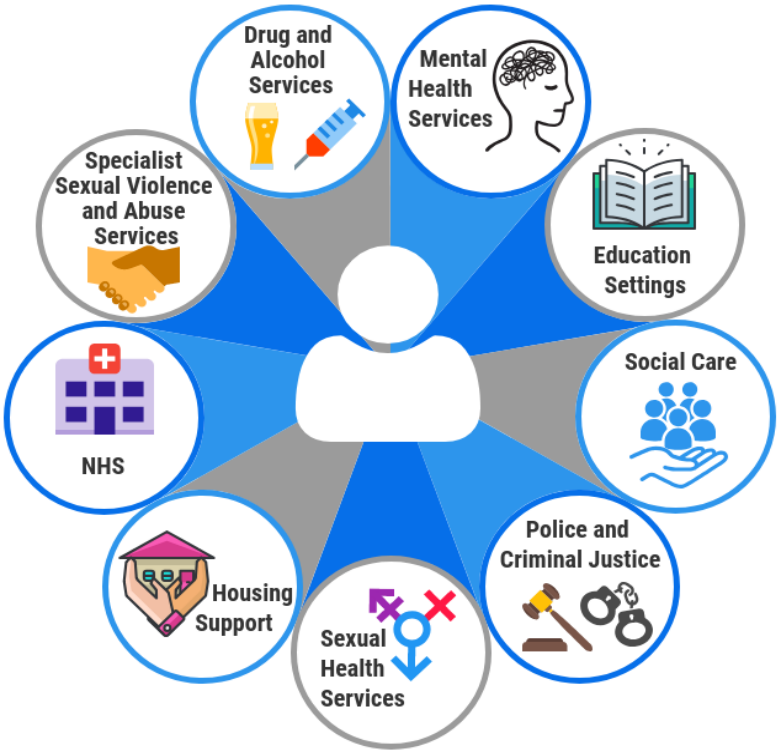
# Chapter 8: Accessing Support

## 8.1 National evidence base

Sexual violence and abuse can have severe psychological, emotional consequences as well as physical impacts. However, when victims/survivors receive the support they need, when they need it, they are more likely to take positive steps to recovery. Being able to access the right support at a time which is right for a victim can be important to help them cope with their experience. There is no generic approach to providing services to victims/survivors of sexual violence and abuse as their needs may be complex and range from individual to individual. For this reason it is imperative that provision should meet the complex needs for victims/survivors.

Due to the wide range of needs that a victim/survivor might have, they may well be receiving support from a range of agencies to help them cope and recover, as demonstrated in Figure 24 below:

*Figure 24: Services that may support a victim/survivor of SVA*




### 8.1.1 SARC Provision

A Sexual Assault Referral Centre (SARC) is a one-stop location where male and female victims/survivors of recent rape and serious sexual assault can have a forensic examination, receive medical care and have the opportunity to assist the police investigation, should they wish.[64]

SARC services should provide equitable access to an individually tailored care package based on comprehensive need assessments, with a choice of action at every stage of care, clinical and non-clinical care and support, forensic examination and referral to appropriate services. The model of service of a SARC may vary according to the demographics and level of sexual violence in an area, and the resources

available within the partner agencies, however, all SARC services are expected to provide the following key elements within their service model to ensure consistency of provision for service users nationally.[65]

The SARC staff are well placed to raise awareness of services available to help victim/survivors cope and recover such as ISVA and counselling. The staff are also able to provide onward referrals to a range of health, social, specialist counselling and mental health organisations according to the preferences and need of the victim/survivor. Victim/survivors who attended the SARC (and consent to follow up contact) are followed up via telephone call at either three or six weeks post-attendance in order ensure aftercare and referrals to additional support services are progressing.

### 8.1.2 Counselling and Advocacy services

A range of counselling services may be beneficial to victims/survivors, some of which are specific to sexual; violence and abuse whilst others may be more generic. Counselling may also be provided by a range of services including clinical services such as Improving Access to Psychological Therapies (IAPT), Child and Adolescent Mental Health Services (CAMHS), private counselling and specialist sexual violence and abuse services. Generic therapy for sexual violence and abuse victim/survivors can include one-on-one therapy, group therapy and, in some cases, medication used alongside other therapies. The type of therapy used depends a lot on the individual and their circumstance but common therapies include:

- Cognitive Behavioural Therapy** (CBT)
- Eye Movement Desensitisation Reprocessing*** (EMDR)
- Supportive counselling.

### 8.1.3 Specialist SVA Counselling

Rape Crisis England and Wales define specialist sexual violence and abuse as 'holistic, victim-centred, and needs-led, and delivered by the third sector (voluntary sector) organisations whose *primary purpose* is the provision of such specialist services.[66]

Specialist sexual violence and abuse services are predominately centred around therapeutic responses, often through the provision of medium to long term counselling. Such services work with victims/survivors who have experienced sexual violence or abuse at any point in their lives. Specialist counselling is generally based around empowerment, resilience building and the ability to cope and recover. Counselling provides a space and opportunity for survivors to explore and work through their experiences of sexual violence and abuse. Specialist sexual violence and abuse counsellors have a profound understanding of the nature of the psychological effects that occur as a result of sexual violence and abuse. Counselling provides the victim/survivor with the appropriate skills and techniques required to enable them to manage such effects that can carry over into post-trauma life. Counselling can also be provided to parents, carers, partners, family and friends of victims/survivors. During

** Cognitive behavioral therapy focuses on the relationship among thoughts, feelings, and behaviors; targets current problems and symptoms; and focuses on changing patterns of behaviors, thoughts, and feelings that lead to difficulties in functioning.

*** A structured therapy that encourages the patient to briefly focus on the trauma memory while simultaneously experiencing bilateral stimulation (typically eye movements), which is associated with a reduction in the vividness and emotion associated with the trauma memories. EMDR therapy differs from other trauma-focused treatments in that it does not include extended exposure to the distressing memory, detailed descriptions of the trauma, challenging of dysfunctional beliefs or homework assignments.

their counselling process, most victims/survivors will go through three stages in recovering from the trauma of sexual violence and abuse:

- Stabilisation and safety building: Overcoming dysregulation
- Managing/coming to terms with traumatic memories
- Integration and moving on. [67]

### 8.1.4 Specialist Advocacy

The consequences of sexual violence and abuse on the lives of victims/survivors are far reaching and advocacy support may be required to support the individual's wider needs. Advocacy is defined as "*taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice*".[68] The primary aim of advocacy is to enable vulnerable individuals to maintain their independence and accommodation within the community in the aftermath of sexual violence and abuse and to put in place safeguards and support to prevent escalation to adult safeguarding.

### 8.1.5 Independent Sexual Violence Adviser (ISVA)

ISVAs play an important role in providing specialist criminal justice system tailored support to victims and survivors of SVA, irrespective of whether they have reported to the Police. ISVAs provide impartial information to victims/survivors about all of their options such as reporting to the Police, accessing the Sexual Assault Referral Centre (SARC) services and specialist support such as pre-trial therapy and sexual violence counselling. The nature of the support that an ISVA provides varies from case to case and depends on the needs of the victim/survivor and their particular circumstances.

### 8.1.6 Pre-Trial Therapy Guidance

The Ministry of Justice's Code of Practice for victims of crime stipulates that victims of crime should be informed that pre-trial therapy is available if needed, and, if requested will be facilitated.[69] Whilst Victims are entitled to pre-trial therapy, guidance from the Crown Prosecution Service (CPS) regarding Pre-Trial Therapy advises that certain clinical therapies such as EMDR and Reprocessing Therapy are not appropriate for victims/survivors who have open police cases. Generally, group therapy sessions should also not be provided, due to the risk of the individual taking on the experiences of others within the group. [70]

Victims and Survivors will need different levels of care and different types of support at different times in their lives and this will be dependent on their circumstances, the pace of their recovery and the level of expertise and support received at the point of disclosure.[71] In order to address and support these needs a holistic and trauma informed approach is most effective. A trauma informed approach is described as below: [72]

> *'One that realises the widespread impact of (psychological) trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatisation'*

Commissioning arrangements of support services is most effective when looking at the holistic approach and recognising the strength of specialist sexual violence and abuse support services within the voluntary sector.

## 8.2 Description of local provider landscape

In Thurrock there are number of services that are able to support victims/survivors of SVA. This includes both specialist and non-specialist sexual violence and abuse services. Specialist SVA services may include SARC provision and specialist SVA ISVA, counselling and advocacy services and non-specialist provision may include support from mental health services, sexual health services, drug and alcohol services, housing support etc.

### 8.2.1 The Sexual Assault Referral Centre

The Essex SARC is delivered by Mountain Healthcare Limited and is commissioned jointly between Essex Police and Fire Crime Commissioner and NHS England. The SARC provides services to any child, young person or adult who have experienced recent or non-recent rape or sexual assault in the geographical area of Essex. The SARC operates from a dedicated facility at Oakwood Place at Brentwood Community Hospital. There are three main referral routes for a client to access the SARC; police, self, or referral by another agency (with consent of the victim/survivor). The SARC is not a drop-in centre as bookings for examination are required prior to attendance. All requests for examination should be made via the Mountain Healthcare call centre who operate 24/7 telephone line. For self-referrals, appointments are made with the client and are available from 8am-8pm, 7 days per week. For young people under the age of 13 years, there is a 7 day a week service and examinations are carried out during 9-5pm during the week and 10-2pm on weekends and Bank Holidays.

The Sexual Offence Examiner (SOE) is responsible for the health and welfare of the victim/survivor attending the SARC. As well as conducting a forensic medical examination, there is a requirement to assess the physical and mental health needs of the client, as well as considering their emotional wellbeing, safeguarding and other vulnerabilities. It is the duty of all staff working directly with the client to consider the client's safety when leaving. A joint risk assessment will be undertaken by the SOE, the police (if present) and the SARC's crisis worker prior to the client leaving.

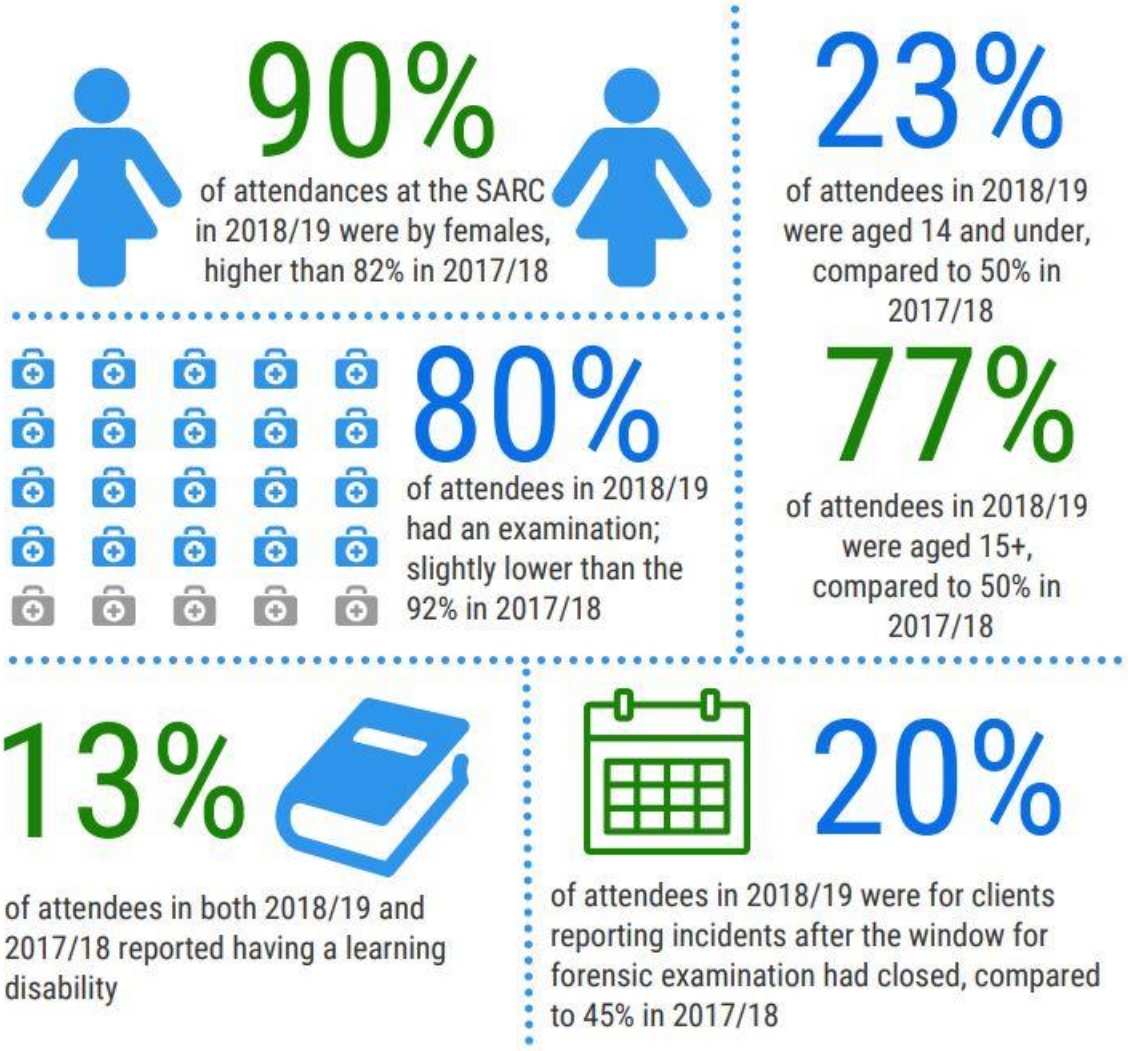
### 8.2.2 Attendances at the SARC by Thurrock Residents

In 2017/18, 38 Thurrock victim/survivors attended the Essex SARC, of whom 45% were referred by the police, 26% by Social Care, 16% by GP/Agency and the remaining 8% were self-referrals.

The number of victim/survivors attending the SARC in 2018/19 was similar, with 30 attendances (of whom 53% were referred by the Police, 20% by Social Care and 22 % were self-referrals, the remaining 5% from A&E/GP's).

The number of self-referrals to the SARC tripled between 2017/18 and 2018/19. Due to the low numbers of Thurrock victims/survivors accessing the SARC, in-depth analysis cannot be published however key findings are included in Figure 25 below.

*Figure 25: A summary of SARC attendances for 2017/18 and 2018/19*




The statistic that 20% of SARC attendees were attending 'late' i.e. reporting incidents after the window for forensic window had closed disguises the variation between paediatric and adult SARC service provision. Data from the SARC shows that approximately two thirds of children seen at SARC were for non-recent incidents of SVA while less that 5-10 % of adults were for non-recent incidents. Due to an absence of data from other areas, it was not possible to compare the SARC attendances made by Thurrock residents with attendances from similar areas.

Of the victims/survivors attending the SARC in 2018/19, 53% had one or more vulnerability factors. This was higher than the 24% in 2017/18. The vulnerability factors are broken down below:

*Figure 26: Vulnerability factors of the SARC attendees*

| | 2017/18 | 2018/19 |
|---|---|---|
| Mental Health | 18% | 45% |
| Learning Disabilities | 8% | 7.5% |
| Domestic Violence | 5% | 17% |
| Self-harm concerns | 11% | 7.5% |

It is to be noted that 45% of victims/survivors attending the SARC in 2018/19 reported having a mental health condition, significantly higher than 18% reported in 2017/18. The SARC have reported that this is attributable to improved data recording amongst their staff. A summary of the onward referrals made from the SARC attendees are included in tables 6-9 below.

*Table 5: Summary of onward referrals (all age groups – whether examined or not examined)*

| Agency | Number of survivors referred | % of all total survivors referred |
|---|---|---|
| **Sexual Health** | 18 | 58% (of those 13+) |
| **Safeguarding** | 8 | 34% (of adults) |
| **Mental Health** | 4 | 13% (of those 13+) |
| **Social Care** | 10 | 71% (of those aged <17) |
| **Children's ISVA** | 6 | 100% (of those aged <13) |
| **ISVA** | 17 | 73% (of adults) |

It is noted that the onward referrals as described above do not match the vulnerabilities identified by the victim's/survivors upon assessment at the SARC. Whilst it was not possible to ascertain whether the survivors who were not referred for onward support were already known to services or had already had a referral made/self-referred, this is particularly relevant for mental health services and sexual health services. Some survivors may have also been allocated an ISVA prior to attending the SARC.

If a Thurrock resident did access another SARC outside of Essex they should be accepted, however there have been incidents where this has not happened. Information gathered by Essex Police indicates that there were no Thurrock residents who accessed another SARC within the East of England region.

### 8.2.2 Specialist sexual violence and abuse counselling

South Essex Rape and Incest Crisis Centre (SERICC) are currently the only sexual violence and abuse counselling, advocacy and support service in Thurrock. The Essex Rape and Sexual Abuse Partnership known as 'Synergy Essex' was formed in 2015 and is comprised of three providers:

- SERICC (South Essex Rape and Incest Crisis Centre) covering South Essex (Thurrock, Basildon, Brentwood, Harlow and Epping)
- CARA (Centre for Action on Rape and Abuse) covering mid and north Essex (Chelmsford, Colchester, Braintree, Uttlesford, Tendering and Maldon).
- SOS (Southend–on–Sea Rape Crisis) covering Southend, Castle Point and Rochford.

SERICC is the lead partner in this arrangement. SERICC receives some dedicated funding specifically for Thurrock and also allocates a proportion of Essex-wide grants, contracts and donations towards Thurrock residents.
Synergy Essex provides a single point of access to specialist sexual violence and abuse services across Essex. Following a referral in to Synergy Essex, a referral is received by the Synergy Essex Triage Team and contact made with the victim/survivor within 48 hours. A risk and needs assessment is conducted and a referral made in to the relevant service as required.

SERICC provides psychological therapy services; offering assessment, signposting and specialist sexual violence and abuse counselling provision to adults, young

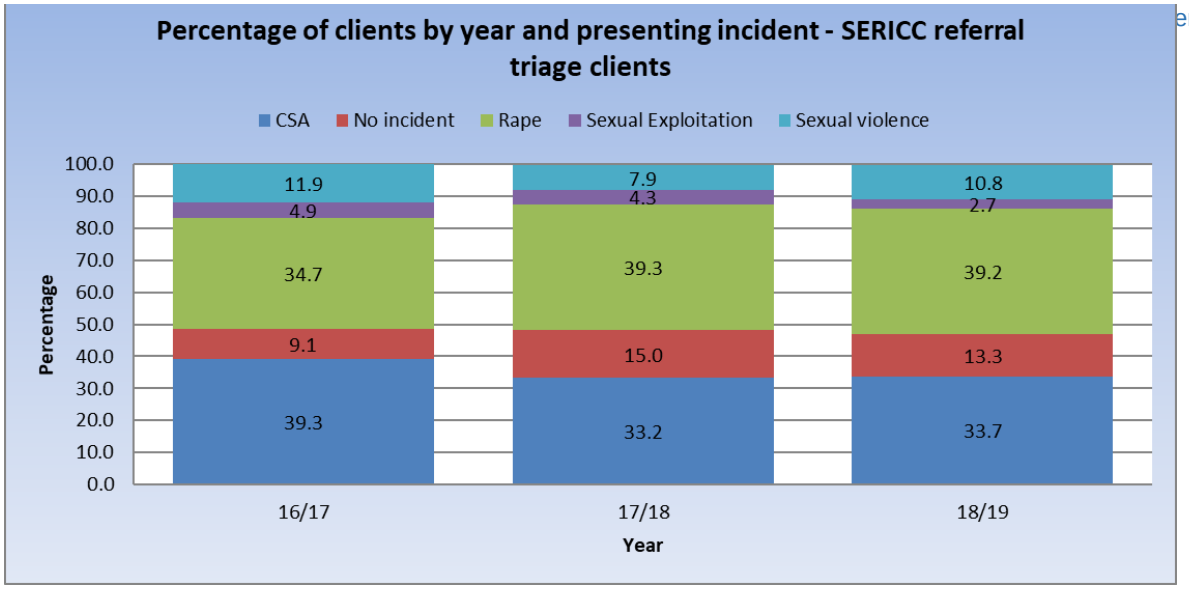
people, children, families and carers who are referred to the service. SERICC's specialist Sexual Violence Counsellors use a wide range of therapeutic approaches including; sensorimotor psychotherapy, resilience and empowerment models, mindfulness, person centred counselling, solution focussed, play therapy, family therapy, couples therapy and art therapy. For those of SERICC's service users who have open police cases, SERICC follows the Crown Prosecution Service (CPS) Pre-Trial Therapy guidance, which along with national research, advises that certain clinical therapies (including EMDR and Reprocessing Therapy) may not be appropriate in pre-trial cases.

SERICC are partly funded by Thurrock Council Local Authority, Thurrock Clinical Commissioning Group (CCG) and the Essex Police, Fire and Crime Commission (PFCC) to deliver a range of services to victims/survivors in Thurrock, as demonstrated below. A summary of each contract and its activity is detailed in Appendix 6.

| | Local Authority (Adults) | Local Authority (Children's) | PFCC | CCG |
|---|---|---|---|---|
| **ISVA: Adults** | | | X | |
| **ISVA: Children's** | | | X | |
| **Advocacy & Floating Support** | Age 16+ | | X | |
| **Family Support** | | X | | |
| **Counselling: Adults** | | | X | Age 18+ |
| **Counselling: Children & Young People (age <25)** | | X | X | Age 18+ |

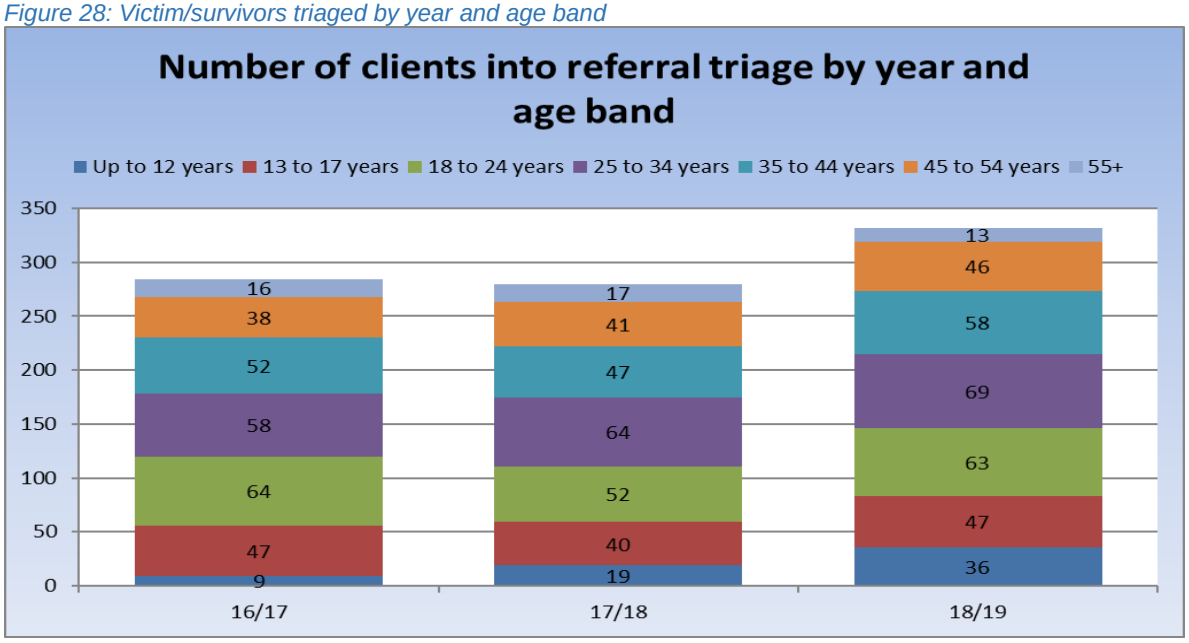
#### 8.2.2.1 Referral Triage Activity

In 2018/19 332 victims/survivors were triaged for specialist sexual violence services via SERICC's single point of access. This has increased from 280 in 2017/18 and 284 in 2016/17. Of those triaged, approximately a third each year presented with CSA, and almost 40% reported a rape. It is to be noted that 'no incident' refers to those who have not experienced sexual violence or abuse themselves however have been affected e.g. partners, parents and siblings.



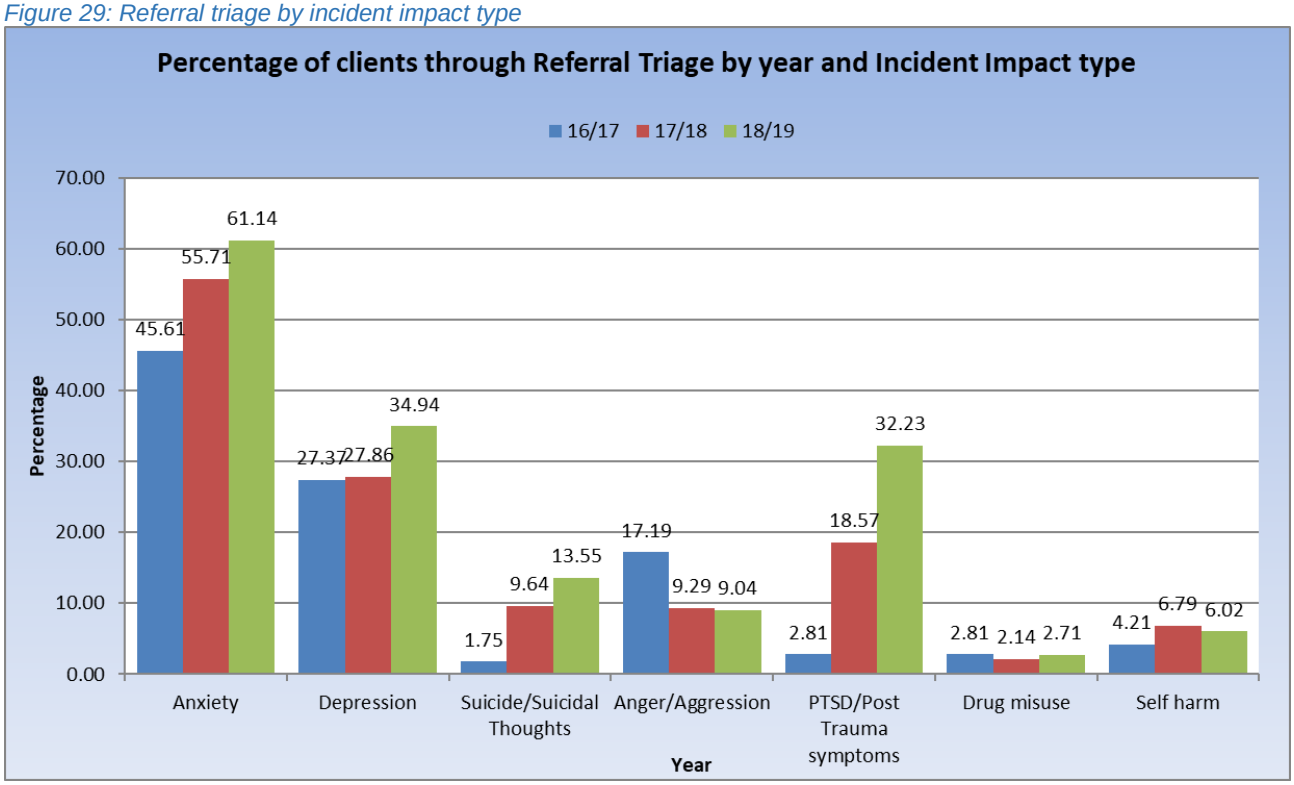

Of these victims/survivors, many were young, with 83 out of the 332 service users in 2018/19 under the age of 18 years. The number of under 12 year olds has increased year on year since 2016/17, as has the number of 45-54 year olds.

*Figure 28: Victim/survivors triaged by year and age band*




Data collected by SERICC also records the presence of other co-existing issues upon entering referral triage. It can be seen from the figure below that over 60% of service users in 2018/19 had anxiety, and around one third had depression. Both of these proportions have increased each year. In addition, **the proportion presenting with PTSD or trauma symptoms has also increased, from 2.8% in 2016/17 to 32.2% in 2018/19.**

*Figure 29: Referral triage by incident impact type*




One other co-existing issue that is not shown in the chart above is the proportion of referrals where domestic violence had either been experienced in the past or was still ongoing at the time of abuse. Domestic violence was recorded on 49 out of the 332 referrals in 2018/19 – equating to 14.8% of cases.

### 8.2.2.2 Usage of SERICC services

In 2018/19 a total of 498 victims/survivors accessed support from SERICC. A breakdown of this usage by service can be found in Appendix 7.

Figure 30 below shows the overall use of SERICC services over the last four financial years. It is to be noted that these totals includes victims/survivors who are accessing more than one service e.g. accessing counselling in conjunction with advocacy services. In 2018/19, 77% of attendees were new and 23% were existing service users.

*Figure 30: The number of SERICC services accessed by Thurrock victims/survivors*

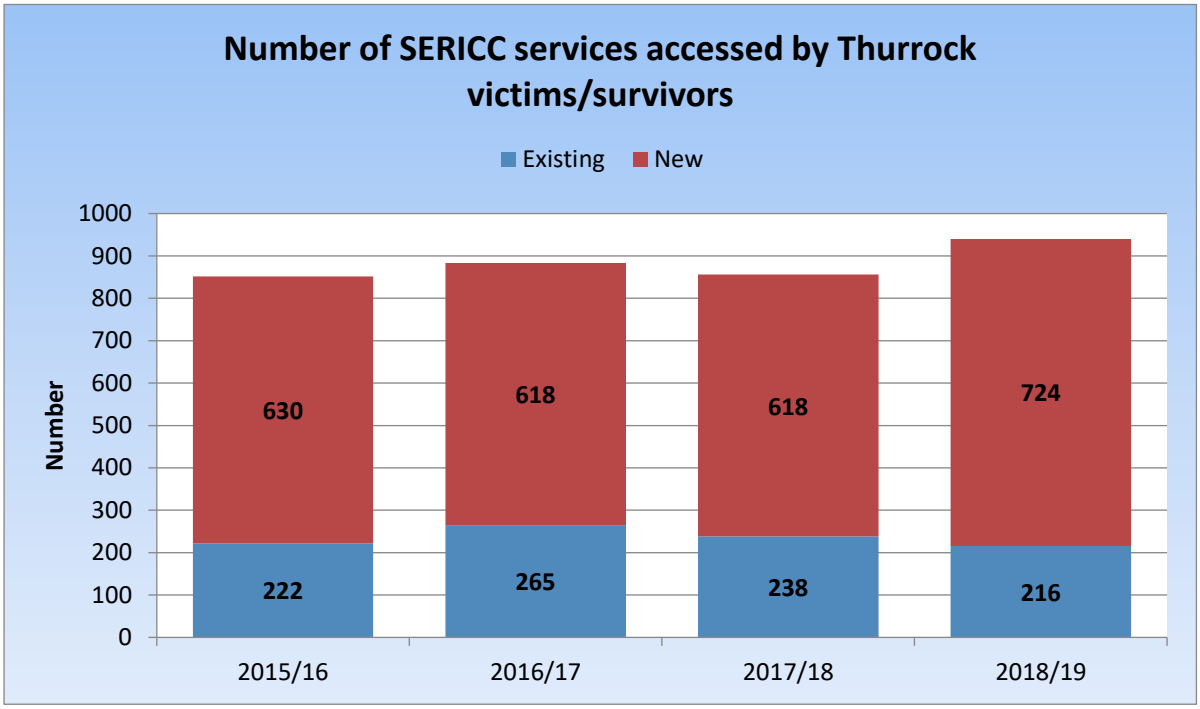



Figure 31 below shows the number of victims/survivors SERICC have supported over the last four financial years. It is to be noted that there has been a year on year increase in the number of victims/survivors accessing SERICC services, equivalent to a 20% increase over the last 4 years.

*Figure 31: Total number of survivors accessing support from SERICC*

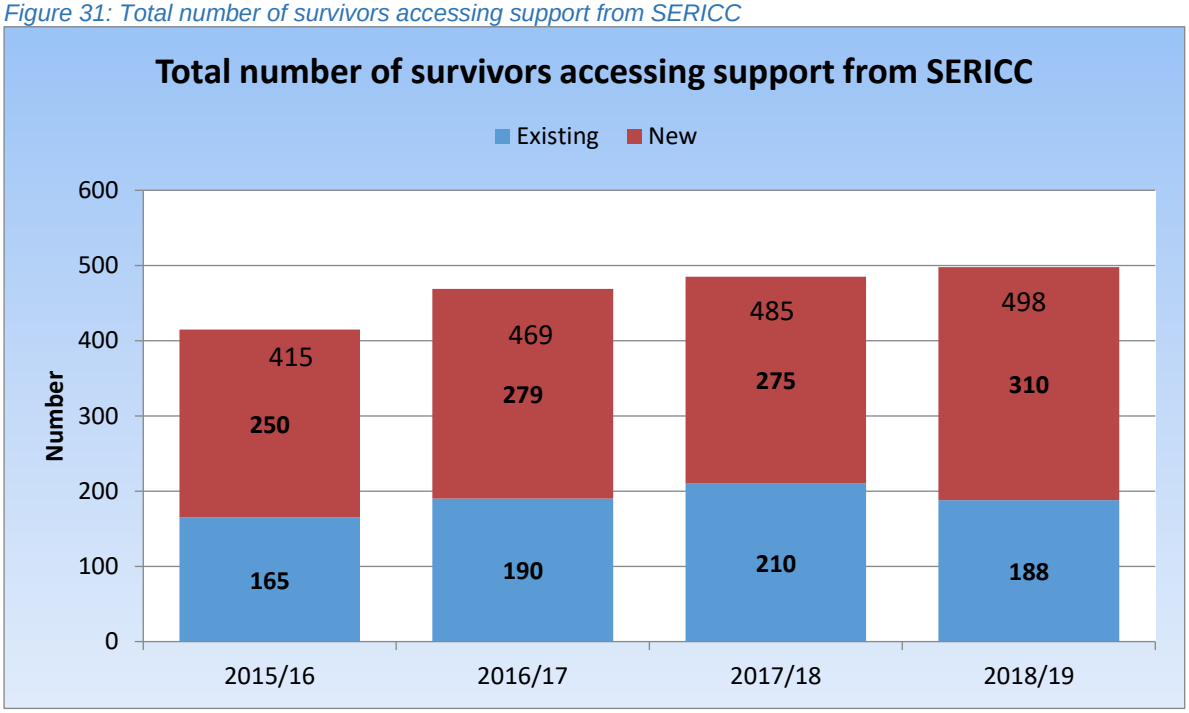


Figure 30 and Figure 31 show that the average service use per victim/survivor is different for new and existing victims/survivors for 2018/19. In 2018/19 there were 310 new survivors who accessed 724 services provided by SERICC, equating to an average of 2.33 services used per person. This was greater than the usage by existing survivors (216 survivors using 188 services, equating to an average of 1.15 services used per person). The way in which specialist SVA services are commissioned locally makes it difficult for the service provider to support survivors holistically as each commissioned service requires separate reporting outcomes.

Further to this, current reporting mechanisms do not take in to account the duration that victims/survivors receive support for, nor does it take in to account that some victims/survivors may require more support than others. This needs assessment therefore lacks understanding of the frequency and duration that local survivor's access specialist SVA counselling and advocacy for.

#### 8.2.2.3 Waiting times for SERICC services

Due to set requirements through commissioning arrangements, SERICC do not have waiting lists for any victim/survivor who lives in Thurrock and is under the age of 25. For victims/survivors aged 25 and over, the average wait time experienced in the year 2018/19 was 49 calendar days for specialist sexual violence counselling. At the point of initial assessment, each victim/survivor is allocated a First Contact Navigator (FCN) who holds their case whilst on the waiting list. During this period, all victims/survivors have access to emotional and practical support via the Synergy Essex information and support line, as well as through their FCN. We were unable to ascertain waiting times regarding specific services within the SERICC contracts.

It is also to be noted that not all victims/survivors want to receive support straight away, particularly counselling. This was evidenced in the local engagement with victim/survivors and the evaluation of the Talking Therapies service.

## 8.3 Non-specialist SVA specific services

It is recognised that victims/survivors of sexual violence and abuse may present at a number of services including those identified in Figure 24. Below are examples of services locally where victims/survivors may attend. Victims/survivors may or may not chose to disclose their experiences whilst accessing these services, however the below seeks to describe what happens when a victim/survivor attends each service.

### *8.3.1 General Practice*

GPs and nurses are able to sign post or refer victims/survivors to a range of appropriate support services including but not limited to; SERICC, Mental Health Services, substance misuse services and sexual health services. They also have a statutory responsibility to refer to Children's Social Care should they have concerns that a child/young person is at risk of harm. Initial investigations have found that there are specific read codes on Systm One (the clinical system used by most GP practices locally) which denote sexual abuse, but the usage of these codes appears to be varied. Local conversations are underway with General Practice in Thurrock to explore the current process and the extent to which they interface with sexual violence and abuse in more detail. Locally, engagement showed that local professionals viewed GPs as a point of referral when receiving disclosures therefore it is imperative that current practices are understood and improved upon if necessary.

### *8.3.2 Hospital*

The main acute hospital that is likely to be accessed by Thurrock SVA survivors is Basildon and Thurrock University Hospital. If it is clear from the initial presentation at A&E that it is related to sexual violence, it should be coded as such. However, it is known that there have been inconsistencies with coding practices both at Basildon Hospital and nationally. This is also the case for the coding of emergency admissions data – running a report on the most relevant national ICD10 code – T742 (sexual abuse) yielded only 65 admissions in 2018/19 across the country with T742 recorded as the primary diagnosis. It could be that other codes are used or that T742 is perhaps coded as a lower diagnosis category than primary – which is likely to be the case if a patient presents with a differing more visible symptom (e.g. there has also been drug use or injuries following domestic violence also). Further work should be undertaken locally to explore this further – including to ascertain how onward support for SVA is offered within both A&E and ward settings.

### *8.3.3 Sexual Health Services*

The Thurrock Sexual Health Service is run by Provide Community Interest Company and provides a range of sexual health and contraception services including HIV and STI testing and emergency contraception. The Service has safeguarding policies in place for children and young people and adults. As part of consultations with service users of all ages, a series of safeguarding questions are asked that may identify previous or current sexual abuse as well as risk factors for vulnerability and exploitation. The assessment process includes a range of questions linked to sexual behaviour with a focus on risks including transactional arrangements as part of sexual activity, thoughts and feelings about sex and partners, as well as details about their sexual partner. The assessment process includes all elements of the 'Spotting the Signs' framework developed by Brook.

For children and young people, all service users under the age of 16 must have a face to face consultation in order to assess Fraser and Gillick competency. All suspected cases of CSE must be referred to the Local Authority, following the Local Authority's threshold, by using the appropriate referral form. This referral is made regardless of any other immediate actions that have been taken to reduce harm to a child or a young person. A CSE Risk and Vulnerabilities Assessment is also completed. An assessment of 'actual' and potential' harm is categorised into Standard Risk, Medium Risk, High risk and Actual indicator of CSE. Any threshold for high level risk and above must be referred to the local authority and concerns should be shared with Essex Police's Operations Centre Triage Team. If a disclosure of rape or sexual assault is made an immediate risk assessment is conducted and dependent on any immediate risk, options are presented or immediate referral is made.

The Thurrock Sexual health Service has very close links with the Essex SARC and robust pathways are in place to support a rapid referral to the Essex SARC for both recent and non-recent disclosure. This referral process ensures that victims/survivors of sexual assault and rape are offered both support and choice with the welfare of the victim/survivor being at the centre of the process.

### *8.3.4 Domestic Violence and Abuse Services*

Changing Pathways are the provider of Domestic Violence and Abuse support services in Thurrock which includes refuge, advocacy and therapy/counselling.

Through the Brighter Futures service, Changing Pathways are also commissioned to provide an eight week therapeutic one-to-one programme for adults with children. Topics included within this programme include understanding abusive behaviours, power and behaviours, strengthening positive relationships, building resilience and self-esteem, speaking to children about abuse and keeping safe (safety and support planning). During the programme, women are empowered to address the issues affecting them and their children. As well as exploring the emotional impact of abuse on them and their children, the programme also provides an opportunity to develop/build on positive parenting, building resilience and emotional well-being after domestic abuse. The staff within the service ask their service users questions related to sexual violence and abuse as part of the Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment. It is has been noted that amongst service users disclosures of sexual violence and abuse are not forthcoming, often attributable to victims/survivors not being aware of what constitutes as sexual violence and abuse. This is particularly the case for those in relationships and requires further awareness.

#### *8.3.5 Substance misuse services*

Inclusion Visions is the adult drug and alcohol treatment service in Thurrock. The service offers a free and confidential service to residents of Thurrock aged 18 and over affected by drug or alcohol use. They support people to facilitate change in their lives through motivation and providing evidence-based interventions. Support may include; one-to-one and/or group work psychological support, substitute prescribing, community or residential detoxification and/or rehabilitation, needle exchange services and health and lifestyle support.

The Wize-Up young person's substance misuse service offers specialist support to children and young people in Thurrock under the age of 18 and their families. The service offers free and confidential advice, information and support to help young people cut down or stop using alcohol or drugs, including new psychoactive substances. The offer includes; specialist one-to-one sessions, support for young people affected by the hidden harm of parental substance misuses, access to counselling, advice and information for parents and carers and support to access other health and lifestyle support.

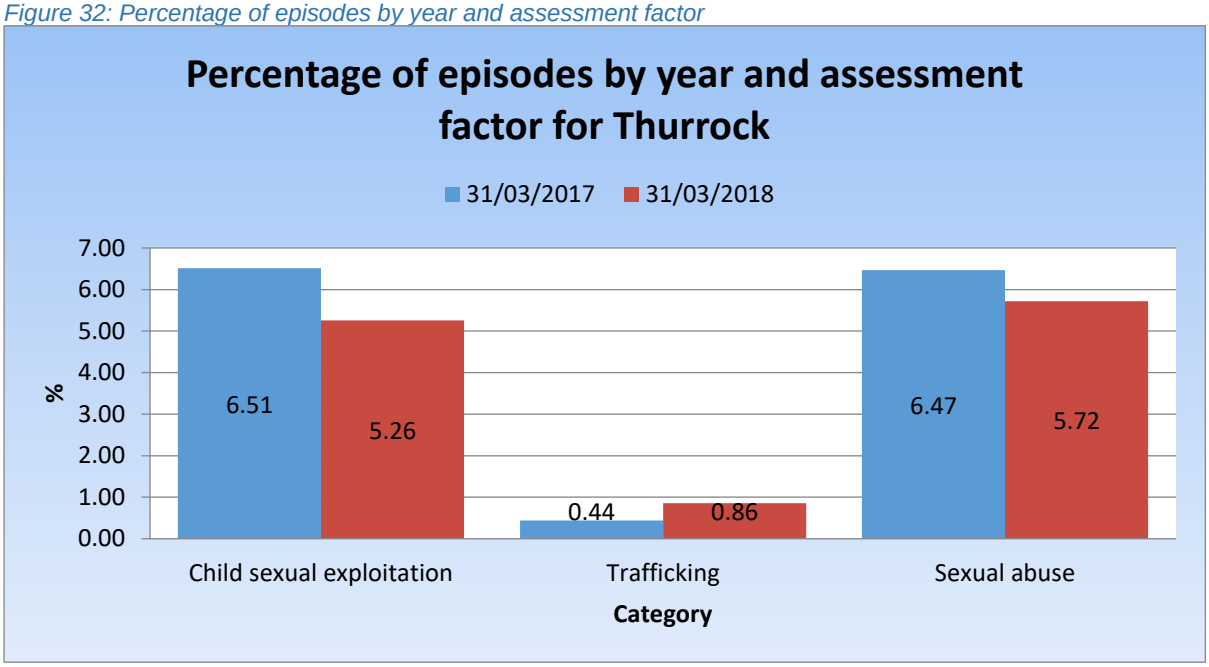
#### *8.3.6 Children's Social Care Provision*

Children and young people who are victims/survivors of sexual violence and abuse may be known to Children's Social Care. Thurrock Council have a Multi-Agency Safeguarding Hub (MASH) in place to handle safeguarding referrals address safeguarding needs appropriately. The purpose of the MASH is to enhance information sharing across all organisations involved in safeguarding the welfare of children in Thurrock - encompassing statutory, non-statutory and third sector sources. Core agencies (including Social Care, health agencies, police, probation, housing, mental health services, sexual violence services, domestic violence services) will ensure that their representatives either sit in the MASH office on specific days or have 'virtual' contact. All partners will work together to provide the highest level of knowledge and analysis to make sure that all safeguarding activity and intervention is timely, proportionate and necessary. Upon receipt of a referral, the MASH 'Hub' will analyse information that is already known within separate organisations in a coherent format to inform decisions. Referrals are then RAG rated and acted on accordingly. Decisions may include referrals in to Children's Social Care services such as the

Prevention and Support Service (PASS) or to specialist sexual violence and abuse services.

As of 31st March 2018, there were 226 children who were subject of a Child Protection Plan in Thurrock. 11 of these had their latest category listed as sexual abuse, which equates to 4.87%. This is slightly higher than the proportion from the previous year, which showed that 4.28% had a latest category of sexual abuse. *It should be noted that the true number of children on Child Protection Plans who have experienced sexual abuse is likely to be higher, due to the fact that the recording process only allows one category of abuse/neglect to be selected; meaning that if sexual abuse was not selected as the highest identifying category, it will not show in the reported figures.* When looking at children classified as Children In Need, as of 31st March 2018 there were 1,749 assessment episodes in Thurrock which supplied information on key risk factors. Of these, sexual abuse was recorded in 100 episodes, 92 recorded child sexual exploitation and 15 recorded trafficking. Comparing this to the previous year, the proportion of episodes highlighting child sexual exploitation reduced (5.26% compared to 6.51% in 2017), and there were no significant changes to proportions identifying sexual abuse or trafficking. It should be noted that each episode can record multiple risk factors on it.

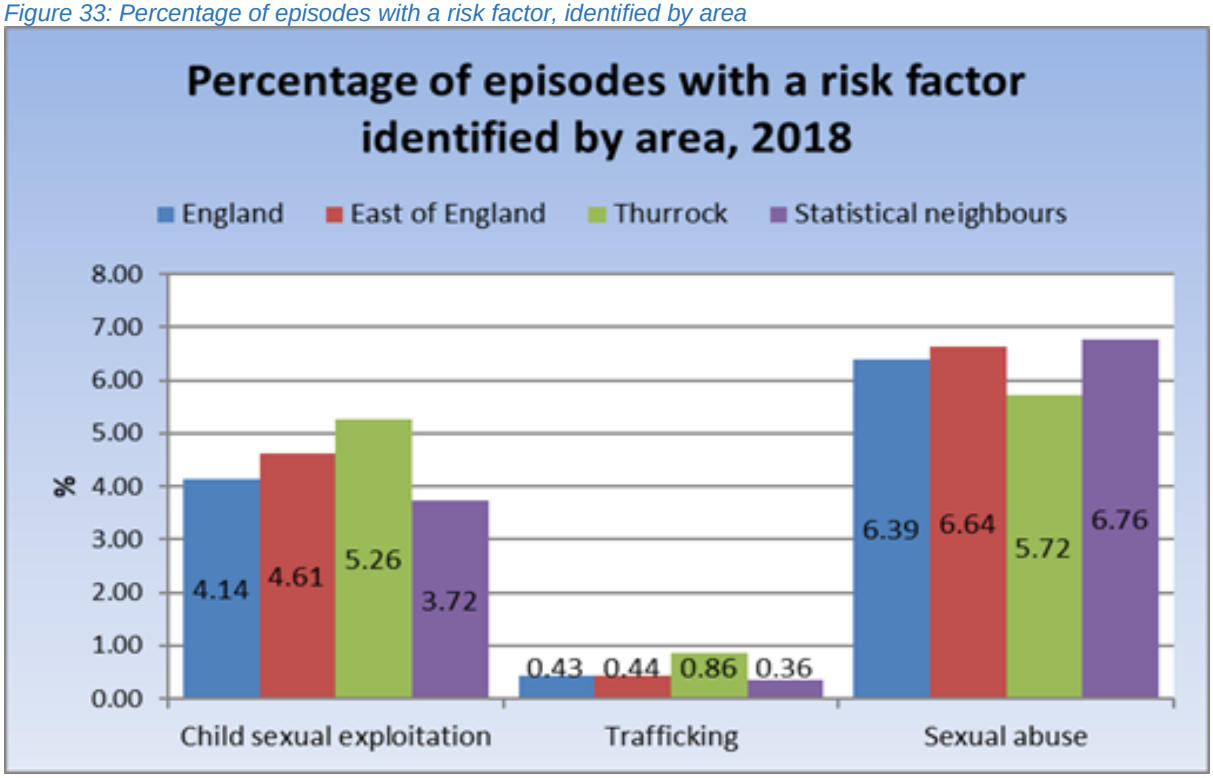
*Figure 32: Percentage of episodes by year and assessment factor*




Source: Children in Need and Child Protection Statistics, 2019

When comparing Thurrock to other areas, Thurrock has a higher proportion of episodes with child sexual exploitation and trafficking recorded, and a lower proportion of episodes with sexual abuse recorded.

*Figure 33: Percentage of episodes with a risk factor, identified by area*




Source: Children in Need and Child Protection Statistics, 2019

## 8.4 Primary and Secondary Care Mental Health Services

A number of mental health services are provided in Thurrock, as summarised in Figure 34 and Figure 35. Further information can be found Appendix 5. It is to be noted that there are some elements of specialist mental health treatment that are provided to SVA survivors presenting with trauma symptoms.

*Figure 34: Mental Health Provision for Adults*

| | |
|---|---|
| IAPT | • Improving Access to Psychological Therapies<br>•Delivered by Inclusion Thurrock<br>•Talking therapies for those with common mental health problems |
| Recovery College | • Delivered as partnership between Inclusion Thurrock and Thurrock MIND<br>• Peer support pivotal component<br>• Open access but specifically for those with a health need |
| Third sector provision | • The biggest provider is Thurrock MIND, who deliver a range of opportunities towards both those with mental health needs and to improve general wellbeing<br>• Support includes counselling, peer support, advocacy and carers provision |
| Secondary Mental Health Care | •Essex Partnership University Foundation Trust provide a range of specialist mental health services<br>•One particularly accessed by SVA survivors is the Personality Disorder Service. Work is underway to transform this pathway |

*Improving Access to Psychological Therapies (IAPT)*

Inclusion Thurrock is the provider of IAPT support to patients aged 18+ registered at a Thurrock GP practice with a common mental health problem such as anxiety or depression. Within the IAPT offer, there are a number of specific services available:

- **Core IAPT** – this is the provision of IAPT therapies to patients with a common mental health problem. This is mandated by NHS England and has a number of monitoring targets to it around waiting times, access and recovery rates.

- **IAPT for those with long term conditions** – this is a newer service which aims to provide IAPT therapy to those where their physical long term condition is a contributor towards their mental ill-health, or their mental health negatively impacts the management of their long-term health condition. Inclusion Thurrock begun trialling this for patients with Diabetes, by developing new referral pathways within pilot GP practices and with long term condition management services provided by North East London Foundation Trust (NELFT). This new pathway will soon be expanded to include a focus on patients with Chronic Obstructive Pulmonary Disease.

- **IAPT Analgesic Pilot** – this is an innovative pilot aiming to provide specialist IAPT treatment to those addicted to legal opioid medications such as morphine products. A pharmacist has been recruited to specifically review and treat patients referred through the pathway, and IAPT therapists are providing psychological support where needed.

As well as the services listed above, Inclusion has been commissioned by Thurrock CCG to provide trauma-focussed treatment to Thurrock victims/survivors aged over 18 years of age, who have experienced sexual violence and sexual abuse at any time in their lives.

Thurrock IAPT have estimated that one third of their patients have experience of sexual assault or sexual abuse in their past. In order to meet this demand the service has continued to invest in ongoing training and development of staff to provide effective, evidence-based treatment for trauma, for example, in February 2017 the service invited a trauma specialist working for the Traumatic Stress Service to deliver a one-day training course on enhanced CBT treatment for trauma. In April 2017, the service began investing in EMDR training for its therapists, and currently have 9 qualified EMDR therapists in post. In December 2019, a further 9 therapists will be undertaking accredited training in EMDR, ensuring that the majority of CBT therapists in the IAPT service can also deliver EMDR. Thurrock CCG recently made a commitment to invest in 2 full time additional trauma CBT therapists to provide continuity of care and named link workers with SERICC to enable the delivery of integrated care models.

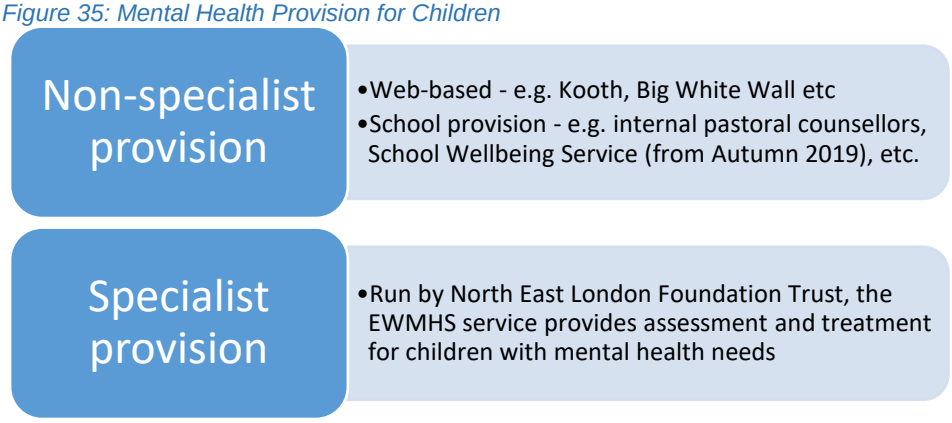
Inclusion Thurrock referred 19 patients to SERICC in 2017/18, all of whom required specialist support for issues relating to their sexual assault, but have not received any referrals directly from SERICC – although survivors might self-refer to Inclusion as that route is also available to them. Work has begun to improve the referral process and improve the joint working for patients known to both agencies.

*Personality Disorder Service*

The current specialist service for those with Personality Disorders is run by Essex Partnership University Foundation Trust (EPUT) and operates across the whole of the county. The service estimates that 70% of the patients on their current PD caseload (circa. 600) have a history of sexual assault and abuse.

There is a transformation programme dedicated to reforming the Personality Disorders service and further developing it within primary care. This should improve the level of joint working between Inclusion Thurrock, EPUT's Psychology team and Thurrock MIND, and should result in improvements to service delivery for patients with personality disorder (and in all likelihood sexual abuse histories). Part of this work also involves rolling out specific personality disorder training to primary care staff to further aid therapists in treating patients with co-morbid personality disorder and sexual abuse trauma. A pilot programme adopting these principles is being scoped currently and if successful will be rolled out across Thurrock.

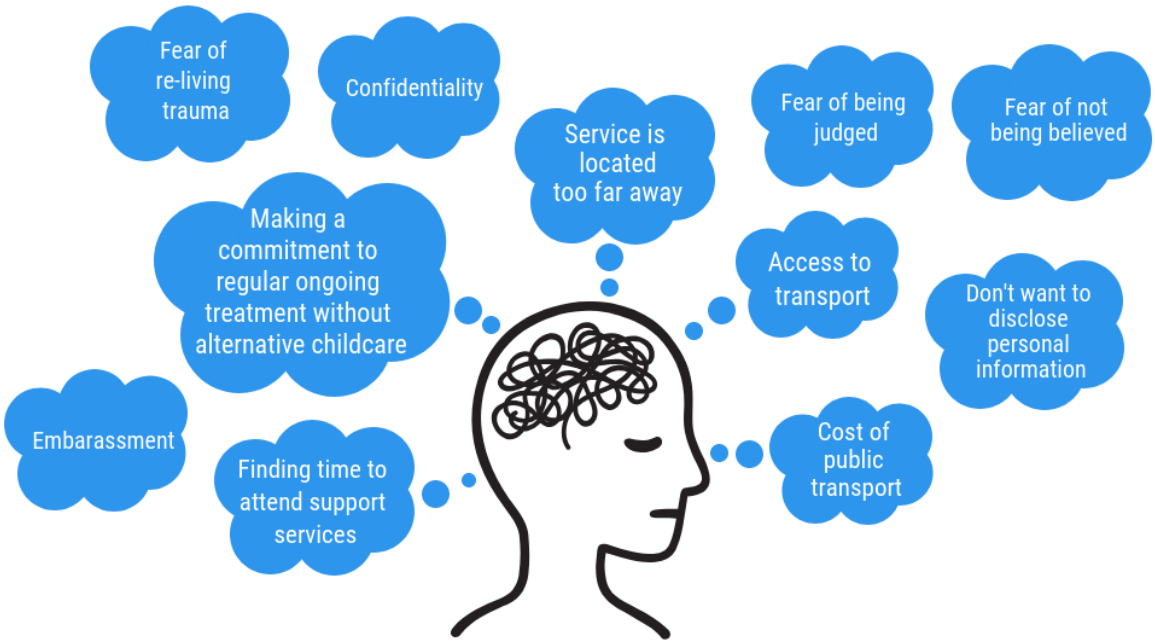
*Figure 35: Mental Health Provision for Children*




## 8.5 Barriers to accessing support

It is recognised that there are a range of barriers to seeking help and support. While these issues tend to affect those from more deprived groups,[73] they are not exclusively barriers of deprivation, with some examples of barriers demonstrated in Figure 36 below.

*Figure 36: Why victims/survivors may not access support*




Some barriers may be particularly pertinent within particular population groups. The 9 protected characteristics within the Equality Act 2010 should be considered; age, disability, gender, marriage and civil partnership, race, religion or belief, sex and sexual orientation.

Social stigma and perception of sexual and gender minority individuals in particular reduce service access and often render service responses inappropriate. This may exacerbate existing distrust of authorities and services among some members of these communities.[74] The lack of services specifically tailored for these populations is also a significant barrier. In a survey of 684 intimate partner violence and sexual violence agencies, 94% of responders said that they did not provide services tailored to sexual and gender minority communities.[75]

Though many barriers are shared across all gender and sexual identities, it is important to understand the cumulative effects of multiple barriers. Beyond gender and sexual identity, victims may also face barriers pertaining to their race, religion, age, language, disability or socioeconomic status. Sex work and drug use can further complicate relationships with formal support services and decisions to disclose sexual violence and abuse.

## 8.6 Recommendations to address problems of access

The following recommendations are made to address problems of access in to local service provision.

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations for improving access to services** | | |
| Survivors reported difficulties accessing the right service(s) at the right time. The extent to which barriers to accessing support occur locally remain largely unknown. Within our engagement work with survivors who had accessed services barriers to support were seldom mentioned, however the needs assessment lacked input from local survivors who were not known to have accessed support. | As part of the implementation of the new pathway of support (see chapter 11) a full communication programme to be effectively implemented to all relevant front line services. This will ensure survivors are able to access the right services at the right time. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | A communications plan to inform the public of the new pathway should be developed. The plan should be informed by survivor's preferences for receiving information in order to increase knowledge and confidence in accessing services. | Thurrock Sexual Violence & Abuse Stakeholder Partnership |
| | Engagement work should be conducted with local survivors who have not accessed support in order to better understand local barriers. | Providers and Commissioners of specialist SVA services |

## 8.7 Issues on local provision

Locally, it is recognised that a number of organisations are involved in the commissioning and provision of sexual violence and abuse services, as identified in section 2.4. The fact that multiple commissioning organisations are commissioning local services recognises the value of specialist support services, however, these services continue to be commissioned in silos by a range of organisations. It is suggested that collaborative commissioning should be explored in order to consider whether the following are advantageous to the commissioners and victims/survivors accessing services:

- Commissioning services at a county-level in order to yield the benefits of economies of scale
- A reduction but ideally avoidance of duplication (e.g. tendering, performance and contract monitoring)
- Streamlined commissioning outcomes.

## 8.8 Victim/survivor voice on experience

The vast majority of feedback from victim/survivors regarding service provision was positive. It is apparent that the majority of survivors had accessed specialist SVA support from SERICC. Survivors frequently spoke highly of the staff within the service received with key themes including; being listened to, believed, respected and supported.

*"SERICC were understanding from the start. They didn't push me or pressurise me. There was no pressure to report to the police or tell anyone else what happened. They just wanted to support me. [The staff member] that I saw was so knowledgeable and not only empowered me but helped me understand why I actually felt the way I did. The building was women only on the days that I went which was something I hadn't thought about before I went but actually meant a lot to me in my sessions."*

Survivors also mentioned positive factors such as the flexibility of appointments, the benefits of group work, being able to meet with others who shared the same experiences, the location and the flexibility of appointments and staff.

Where negative feedback was provided, these included instances of waiting times, not being believed by staff, finding mutually convenient appointment times, barriers related to transport, difficulties accessing specialist SVA counselling and mental health services in conjunction with each other. It is to be noted that the organisations referred to above were not always mentioned.

The video below shows survivors the responses of local survivors when asked what support they hoped for and what support they received.

## 8.9 Recommendations to address issues with existing overall service provision

The following recommendations are made to address issues with service provision.

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations for improvements to existing service provision** | | |
| Engagement with survivors recognises that they value a holistic offer of support and there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is perhaps needed to reduce these inconsistencies | Providers and commissioners of specialist SVA services should agree a new integrated model and care pathway of support and then jointly commission/deliver it. The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services.<br><br>The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop). | Providers and Commissioners of specialist SVA services including Adult and Children's Social Care Commissioners, Mental Health Commissioners at NHS Thurrock Clinical Commissioning Group |
| Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways, waiting times, quality. Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes. It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres), there may be benefit in commissioning more SVA services at a county-wide level. However, it is to be noted that this needs assessment was solely focussed on Thurrock and therefore further work is required in order to ensure an appropriate offer is provided across Essex. | Local survivors should be invited to co-produce the new pathway of support and their views are used to develop services and form part of quality assurance of commissioned services. | Providers and Commissioners of specialist SVA services |
| | Adult and Children's Services Commissioners in Thurrock Council and NHS Thurrock CCG should review existing mechanisms for recording performance outcomes within specialist SVA services with the ambition to agree a consistent approach to monitor SVA outcomes within local contracts. | NHS, Council and Criminal Justice commissioners of specialist SVA services |
| | Council and NHS commissioners should integrate commissioning of SVA services and seek to develop a single contract, shared budget, single outcomes framework and collaboratively commission specialist SVA services across Essex. | NHS and Council Commissioners of specialist SVA services |

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| | Specialist SVA services should be commissioned based on the evidence base presented within this needs assessment and accounting for data which will be collected through the proposed recommendations. | NHS, Council and criminal justice commissioners of specialist SVA services |
| Local engagement with survivors identified that over 50% said they waited for less than one month before receiving support, however, some survivors reported finding it hard to be on a waiting list once they made the decision to access support | An offer of emotional and practical support must be made available to all survivors on the waiting list for specialist SVA services. This could be informed by the evaluation of the locally delivered Synergy Essex '*First Responder Project'.* | NHS, Council and Criminal Justice commissioners of specialist SVA services |

# Chapter 9: Ascertaining the suitability of current support services to meet needs of all SVA survivors

## 9.1 Issues with current provider landscape

This needs assessment has identified a number of issues with the current provider landscape, as described below:

- Locally, multiple services are commissioned to support survivors however they are mostly working to different outcomes.

- It is recognised that certain contracts related to SVA are commissioned at a county-wide level, considering the close proximity of all three local authorities in Essex (as well as sharing the same Police force, hospitals , SARC and single point of access for Rape Crisis Centres)

- Local survivors told of how their experiences of service provision has not always met their needs or expectations e.g. due to fragmentation of pathways.

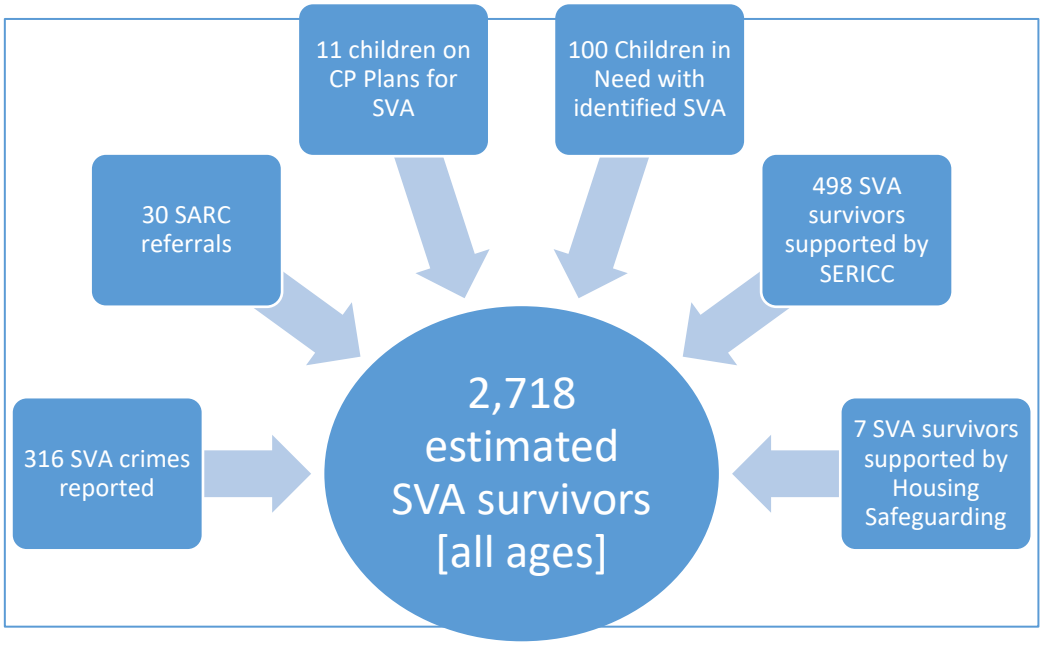
## 9.2 Quantifying the gap locally

It is difficult to establish an accurate level of need for sexual violence and abuse services in the Thurrock population. This is attributable to a number of factors, including:

- underreporting of sexual violence and abuse offences to the Police
- the length of time between the incident(s) and reporting to the police
- the length of time between the incident(s) and accessing support
- a lack of information sharing between agencies supporting survivors
- agencies not collecting information regarding whether or not the victim/survivor has reported to the Police
- victims/survivors may be accessing multiple services within the same organisation and therefore posing a risk of 'double-counting'
- victims/survivors may be accessing support for recent and non-recent sexual violence and abuse

As mentioned in section 3.2, it is estimated that the number of Thurrock residents who experienced sexual violence and abuse within the last year is approximately 2,718. As outlined in the various sections above, SVA victims/survivors are seen by a range of services and organisations. What we were able to establish is summarised in the diagram below:

*Figure 37: SVA survivors being supported in Thurrock - 2018/19*




As mentioned in sections 3.3 and 8.3 it not been possible to define the level of SVA presenting in GP and hospital settings. In addition, *it is not possible to deduce overlaps between those accessing services.*

Age is captured in differing age bands per service, but our data indicates that a large number of our known victims/survivors are young:

- The 100 children who are CIN and 11 who are subject of a CP Plan due to SVA are all aged 0-17 years – although as above, there may be other children with SVA known to Social Care who do not have SVA as their primary vulnerability factor

- 7 of the 30 SARC attendees were aged under 14 years

- 187 of the 316 reported crimes were aged 0-17 years when the incident occurred [59.2% of all reported SVA crimes]; although there were only 151 crimes reported by 0-17 year olds, indicating that some of these young people waited for a while before disclosing to the Police

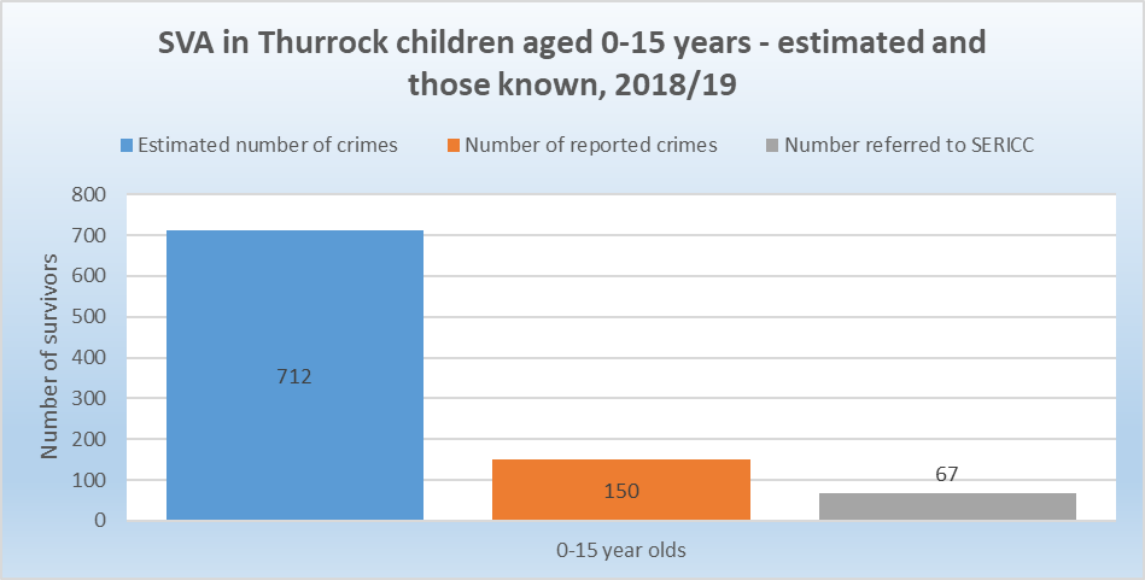
- 25% of the referrals triaged by SERICC in 2018/19 were for those aged 0-17 years – equating to 83 individuals.

- As mentioned in sections 8.3.1 and 8.3.2, it has not been possible to define the age profile of SVA in GP and hospital settings

The chart below looks to show the likely need for children aged 0-15 years in context with the numbers we know of in terms of recorded crimes and those known to SERICC.

It was not possible to directly compare the other data mentioned above relating to young people because of the differing age groups; however it can be seen that there is a large amount of unmet need in children also – despite large proportions of those known to services being younger. Approximately 21% of the expected number of crimes to 0-15 year olds were reported to Essex Police last year, and SERICC received referrals for only 9.5% of the estimated activity for that age group.

*Figure 38: SVA in Thurrock children aged 0-15 years*




Source: CSEW, Essex Police and SERICC data

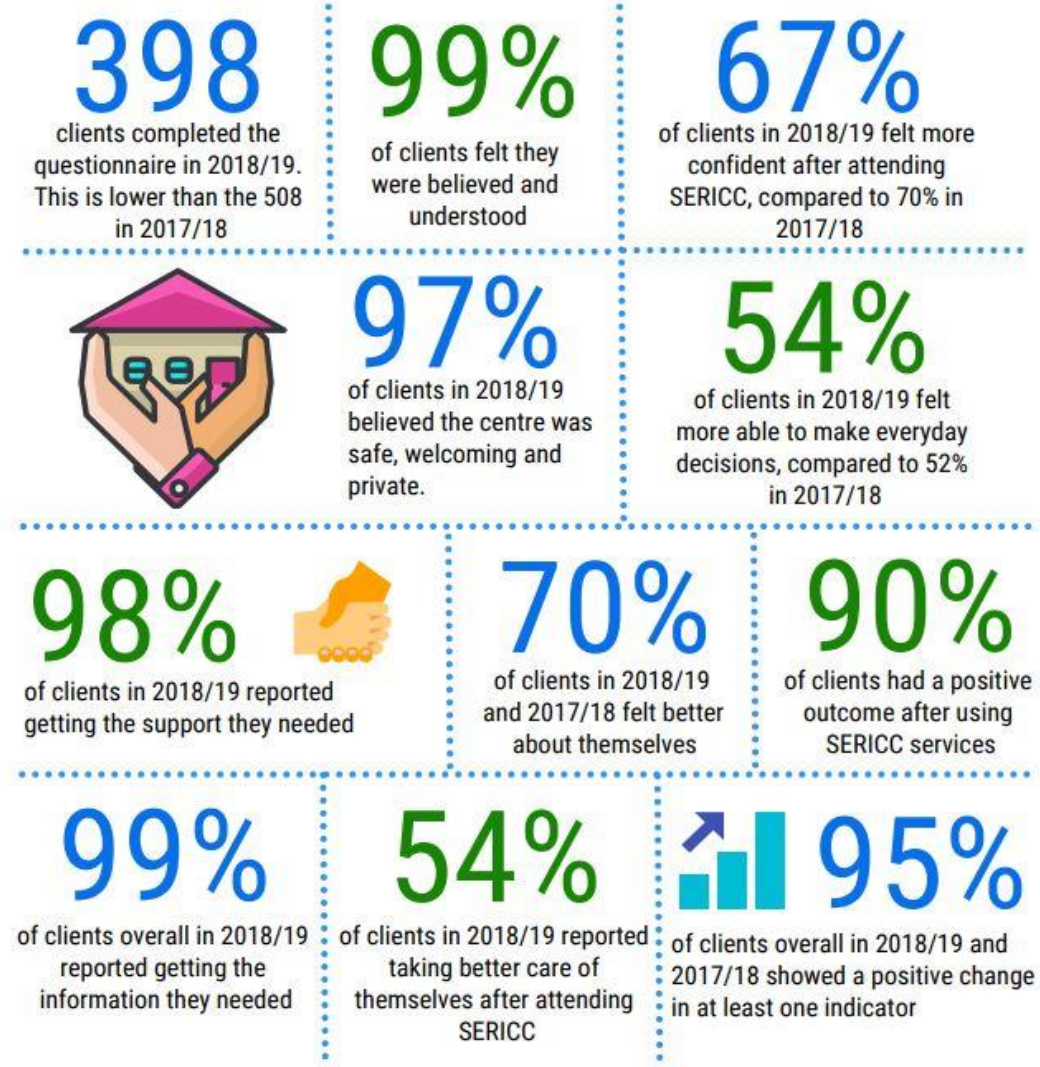
It is also to be noted, due to the low reporting rate of SVA offences to the Police, this data is not entirely representative of the type of sexual violence and abuse occurring in Thurrock. Considering the age groups of these young people, they *may* be more likely to be able to disclose and report their experiences due to increased opportunities for safeguarding etc., however the extent to which this impacts disclosure is unknown. The number of young people displaying harmful sexual behaviours is of concern and further exploration is required in order to understand this further. It is thought that lack of concern regarding consent, changing attitudes towards relationships and sex amongst young people and access to pornography may be contributing factors.

## 9.3 User voice

### 9.3.1 SERICC pre and post questionnaires

As part of their contract monitoring and evaluation of service provision and service user satisfaction, SERICC ask victims/survivors questions upon commencing the service and the same questions during their last session. A summary of the findings from 2017/18 and 2018/19 are included in Figure 39 below.

*Figure 39: Findings from the SERICC before and after questionnaires*




### 9.3.2 Findings from the engagement

Findings from the engagement regarding service provision were generally very good, however it must be noted that the majority of survivors who responded appeared to have accessed specialist service provision from SERICC and are likely to be those who have contributed to the views above in Figure 39. It is to be noted that some survivors mentioned waiting times to access services however did not specify which service(s) this was in reference to.

Survivor's perceptions of how services worked together were varied. Of the 44 survivors who responded to this question; 64% felt services worked together very well, 7% well, 7% were neutral and 23% felt services worked together poorly. A range of services were mentioned however it was noted that a number of survivors mentioned SERICC supporting them with Social Care. Some survivors also mentioned that they wished to receive mental health support as well as specialist sexual violence support however were informed that they were unable to receive mental health whilst accessing specialist support. Examples of local survivor's views are included below:

"When my SERICC worker contacted mental health as I was struggling the mental health team said I couldn't see them if I was having counselling at SERICC."

"SERICC worked really well with the drug and alcohol support services, social services, police, sexual health etc... SERICC have always provided a support worker I knew to take me to appointments and support me to have a voice at meetings etc...These other services have worked together with SERICC to ensure I had the best support."

"Mental health group in Grays not allowed to see me until SERICC has stopped seeing me as the woman from the group said you can't have two support at once."

"Extremely well giving me the support and guidance I need. SERICC and Changing Pathways have been brilliant."

The video below includes local survivor's accounts of the support they received.

## 9.4 Professionals views

Of the 128 professionals who provided their thoughts regarding whether services worked well together to provide support to survivors; 43% felt yes, 22% felt variably, 21% didn't know and 14% felt no. When asked how this could be improved the most common responses were to increase collaboration, communication between services and to provide continuous awareness of the services available to support survivors. Examples are included below:

"We all work very separate and perhaps having opportunity to meet these other services ourselves would help with better working practices"

"I believe services do their best, however I feel as though services need to communicate better and take a holistic approach so that the service user has an easier journey. I feel as though not enough information is shared amongst services and sometimes staff members can take a long time to reply to emails"

## 9.5 Recommendations

Collaborative working is required between services that support survivors in order to support survivors holistically and break down working in silos. The following recommendations are suggested in order to improve collaborative working:

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| Engagement with survivors recognises that survivors value a holistic offer of support, there is also a strong body of evidence in favour of this. However, local engagement with professionals and survivors identified that services do not always work together and where partnership working does occur, there is often fragmentation of pathways indicating more work is perhaps needed to reduce these inconsistencies | The new pathway of support (as proposed in chapter 11) is to be further developed in consultation with survivors and all relevant services.<br>The new pathway should be tested by local professionals in order to ensure it works effectively and expose any flaws or issues (e.g. through a dedicated training workshop). | Providers and Commissioners of specialist SVA services |

# Chapter 10: Local safeguarding and strategic focus

## 10.1 Local Safeguarding arrangements in Thurrock

The Care Act of 2004 requires every local authority to establish a Safeguarding Children's Board (LSCB) and the Care Act of 2014 requires every Local Authority to establish a Safeguarding Adults Board. The safeguarding arrangements in place in Thurrock are either determined at a local level or county wide, otherwise known as SET (Southend, Essex and Thurrock). These are listed below and further information can be found in Appendix 8.

- Local Safeguarding Children Partnership (LSCP)
- Local Safeguarding Adults Partnership
- SET Child Protection Procedures
- SET Vulnerable Adults Policy/Guidelines.

## 10.2 Existing Networks and Strategic Groups

A number of networks and strategic groups are in place at a local and county level. These are listed below and summarised in Appendix 9. Local groups include:

- Thurrock Community Partnership (CSP)
- Thurrock Violence against Women and Girls (VAWG) Strategic Group
- Missing children: Risk Management Meeting
- Multi Agency Child Exploitation Group (MACE)
- Addressing Gang Related Violence Meetings
- Multi-Agency Risk Assessment Conference (MARAC).

Regional groups include:

- Southend, Essex and Thurrock (SET) Strategic CSE Board
- Essex Sexual Abuse Strategic Partnership (SASP).

The Essex SASP is a multi-agency partnership which includes a range of providers and commissioners from the health sector, criminal justice agencies and local authority. The partnership is chaired by Essex Police which meets quarterly. The objectives of the partnership are to:

- Provide strategic leadership to address sexual violence and abuse in Southend, Essex and Thurrock
- Develop a partnership sexual violence and abuse strategy, which sets out and monitors the key shared outcomes partners are seeking to achieve through collaborative work around sexual violence and abuse. The strategy is currently being developed and is due to be published towards the end of 2019.

- Understand and review the performance of local sexual violence and abuse support services and their impact

- Seek new ways of working together and promote best practice

- Hold each other to account for complying with appropriate legislation and statutory responsibilities in addition to monitoring the effective delivery of the partnership Sexual Violence and Abuse Strategy

It is anticipated that the Essex SASP will play a key role in supporting the implementation of the majority of the recommendations proposed as part of this needs assessment, particularly those at a county-wide level. This will ensure the benefits of having shared county-wide resources including a shared SARC, hospitals, Police Force and single point of access for Rape Crisis Centres within Essex are fully utilised. It is to be noted that whilst there are a number of existing networks and groups in Thurrock that reference SVA, however none of which explicitly focus on SVA and therefore locally SVA is often neglected of the dedicated attention required.

## 10.3 Recommendations

The following recommendations are suggested in order to improve the local strategic approach to sexual violence and abuse.

| Issue Identified | Recommendation to address this | Responsibility |
|---|---|---|
| **Recommendations around improving strategic oversight for SVA** | | |
| There are already a large number of existing strategic groups, networks and leadership opportunities to champion this agenda, however it is not quite clear where the lead responsibility sits locally | Form a dedicated Thurrock Sexual Violence and Abuse group reporting in to the Thurrock Violence Against Women & Girls Strategy Group (it is to be noted that despite the name, this group also address men and boys). This group will provide a focal point for SVA and drive the majority of recommendations from this Joint Strategic Needs Assessment. | Thurrock Community Safety Partnership |
| | Advocate for provision of SVA to be included in the refresh of the Health and Wellbeing Strategy for Thurrock in 2020 so that there is a continued strategic focus on this agenda. | Thurrock Council Public Health Service |
| Locally, there are a number of existing policies, in place, particularly those related to safeguarding, where there is scope to strengthen the presence of SVA to ensure a partnership approach to supporting victims/survivors of SVA working towards prevention and reduction | Thurrock's Adult and Children's Safeguarding Boards should take a proactive approach to addressing SVA, including:<br>-Policies are reviewed and detail clear responses to SVA<br>-Ensuring professional adherence to policies and guidelines<br>-Supporting professionals to feel confident in understanding and addressing SVA. | Thurrock's Adult and Children's Safeguarding Boards |
| | Thurrock's Adult and Children's Safeguarding Boards should support partner organisations to produce policies that address SVA, whether this is included within a generic safeguarding policy or as a standalone policy. This should include:<br>- Training requirements<br>- Information gathering/collection<br>- Information sharing<br>- Safeguarding protocol/standards<br>- Safeguarding supervisions (where appropriate). | Thurrock's Adult and Children's Safeguarding Boards |

# Chapter 11: A vision for future service provision

## 11.1 High level vision and principles

Locally, our vision is to improve the response to disclosures of sexual violence and abuse and facilitate access to services that support victims/survivors to cope and recover from the impacts of their experience and rebuild their lives, whilst also seeking to prevent these crimes occurring in the first instance.

This will only be achieved through the following:

- Ensuring a dedicated local approach to tackling sexual violence and abuse
- Ensuring victims/survivors are provided with appropriate high quality services that support them to cope and recover
- Driving collaboration amongst all relevant organisations and partners and developing a workforce that views SVA as everybody's responsibility and a shared priority
- Reducing fragmentation in service provision within the local provider landscape
- The provision of holistic support to victims/survivors, ensuring survivors receive prompt access to the support they require from the services they require
- Ensuring the commissioning of services that are based on outcomes, rather than focussed on activity
- Improving operational aspects within the local provider landscape and workforce i.e. working towards a system where SVA is reported and recorded properly and a workforce who handle disclosures sensitively and appropriately and make onward actions as appropriate
- Respecting the needs and preferences of local survivors as identified through this needs assessment, e.g. survivors are not required to unnecessarily repeat their story more than required and chase referrals in to services

A new pathway of support should be developed and introduced. This pathway will ensure that all victims/survivors who make a disclosure of sexual violence and abuse to a professional within the Thurrock workforce are informed of and offered referrals into the services available. Further information regarding this pathway is detailed below.

## 11.2 Proposal of a new pathway of support

This needs assessment identified a number of issues with the current provision of support services for survivors of SVA. Engagement with local professionals and survivors identified that:

- Survivors reported difficulties understanding and navigating the complex landscape of support services
- It is frustrating and traumatic for survivors to 'repeat their story' multiple times to a number of different professionals
- There is a lack of collaborative working amongst professionals to ensure the needs of survivors are appropriately met.

The ambition of the new pathway of support is to ensure all survivors who make a disclosure of sexual violence and abuse are provided with access to a full range of services to help them cope and recover from their experience. The most appropriate way to achieve this is for survivors to undertake a single, comprehensive and holistic assessment which seeks to identify any needs or requirements for support that they may have. This assessment should be conducted by a specialist sexual violence and abuse agency wherein the staff have the appropriate knowledge and skills to support victims/survivors.

Following the assessment the specialist SVA agency will be responsible for liaising with the relevant support services and broker a tailored support offer which is personalised specifically for the survivor. Through these discussions, the specialist SVA agency will be able to provide the support services with an overview of the survivor's information and their identified requirements, therefore reducing the number of times survivors are required to repeat their story.

The specialist agency will maintain regular contact with the survivor whilst the survivor is accessing support from the other support services. This will enable the specialist agency to check the status of the referrals, monitor the survivor's compliance with accessing support and review the survivor's progress against their goals.

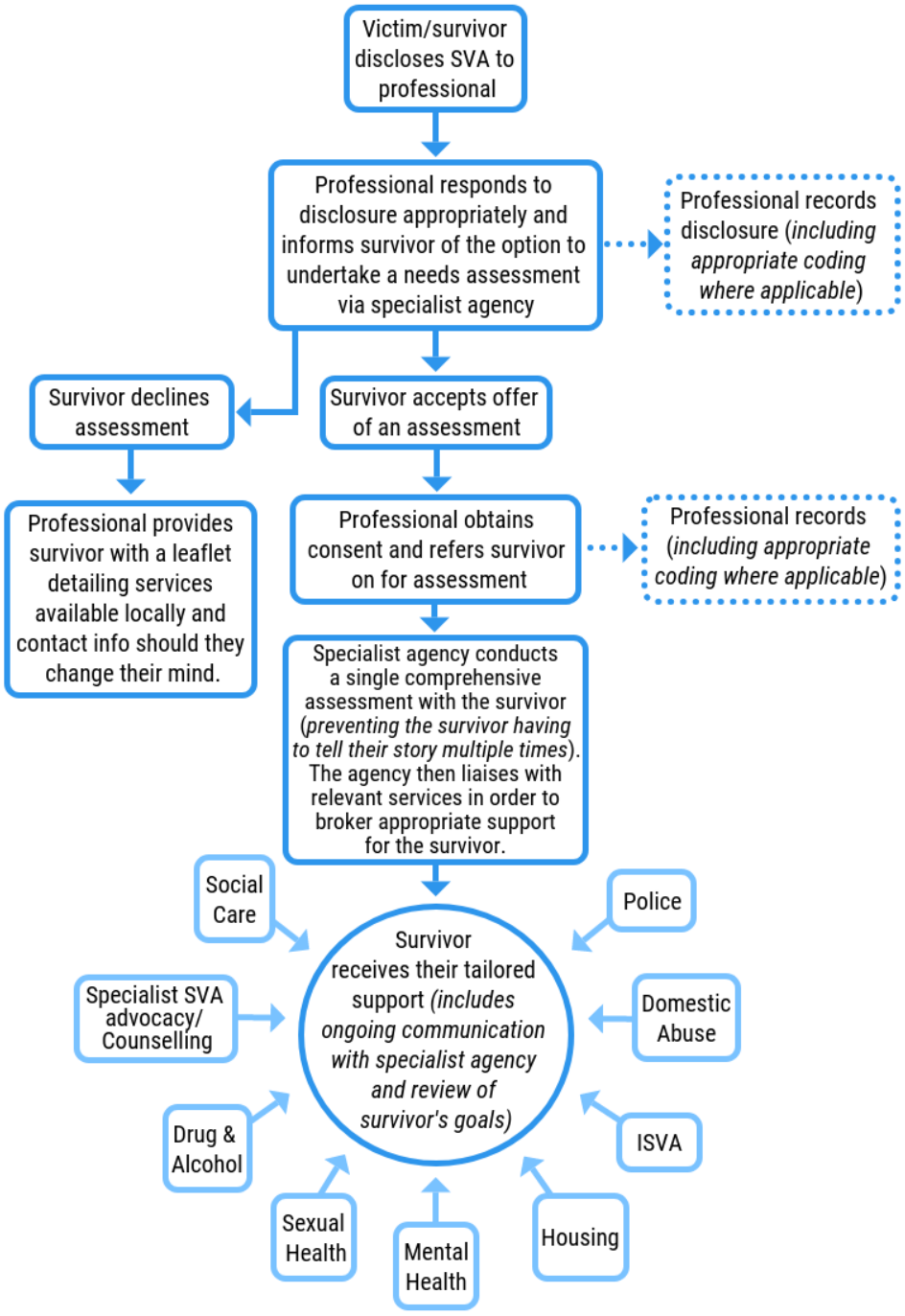
This pathway will address the majority of issues identified within this needs assessment through ensuring:

- The providers who may be required to support survivors of sexual violence and abuse, regardless of which sector they work in, work in partnership to provide a holistic offer of support to survivors
- Every survivor who discloses to a professional in Thurrock is offered the option to be referred to a specialist agency in order to undertake a full and holistic needs assessment in order to identify any services they may benefit from in order to help them cope and recover
- Referral processes are significantly improved, yielding the following benefits:
    - Less confusion for professionals and survivors
    - Referrals are made in a timely manner
    - Minimising the number of times they are required to 'tell their story'

In theory, the assessment that a survivor undertakes should act as a survivor's '*passport*' in to services. An illustration of how this proposed pathway may look is included in  below/

Figure 40 below/

*Figure 40: The proposed pathway of support*




Whilst an overview of the proposed model of support has been provided, a number of factors must be considered in greater detail by all parties involved (i.e. commissioners, service providers and local victims/survivors). Some initial considerations are summarised below:

| | |
|---|---|
| **Expertise** | It is suggested that the agency conducting the assessment is one which has specialist expertise in supporting victims/survivors of sexual violence and abuse. The frequency at which the assessments are reviewed should also be considered. |
| **Finances** | It is recognised that such a model would be an addition to already existing delivery and consideration should be given to how and by whom this can be funded. There is also the potential that if awareness of available support options increases and the access mechanisms are streamlined, it could increase demand on wider services, thereby increasing financial pressures across a range of organisations. |
| **Outcomes for survivors** | It is imperative that this pathway is effective in meeting the preferences and requirements of victims/survivors. In order to seek that this pathway is monitored on outcomes rather than being solely focussed on activity. It is suggested that upon initial assessment, or soon after, survivors are asked to set goals based on what they would like to achieve through the support they receive from the service(s) they wish to access. The progress of these goals may be used as a tool to monitor the effectiveness of the new pathway. |
| **Communication between organisations** | In order for a collaborative approach to be successful, effective communication is required between all organisations involved in the pathway. The following basic principles must apply:<br>- Providers must acknowledge receipt of referrals<br>- Providers should provide the specialist agency with relevant updates regarding the status of referral and whether the victim/survivor attended the service or not<br>- Providers should inform the assessor of any updates relevant to the pathway or service e.g. changes to services offered, eligibility criteria or contact information. |
| **Reporting** | It is proposed that a new pathway should include robust reporting outcomes and quality indicators in order to monitor its effectiveness. A high level reporting template must be developed to include key reporting requirements such as; the demographics of victims/survivors, goals set and progress against these goals, the number and outcomes of referrals to services and adherence to assessments. Reporting requirements should be agreed with all relevant stakeholders. |
| **Co-production** | This model of support should be developed in collaboration by all key agencies/ organisations who may support victims/survivors of SVA. These assessments should also be discussed or trialled with local victims/survivors in order to ensure they are effective and appropriate. Information sharing agreements and mechanisms may also require development. |
| **Governance and Oversight** | The oversight arrangements around this model would need to be agreed between all agencies; whether this becomes a function of the new Thurrock SVA group or an agreement underneath an existing commissioning forum. If this is adopted |

| | |
|---|---|
| | as a SET wide approach there is the possibility of the Essex SASP supporting with this function. |

### 11.3 How the new model addresses issues identified

The new model/offer of support as described above would address some of the key issues identified throughout this needs assessment, namely:

| Issue | Way in which the model will address this |
|---|---|
| **Current data systems are not set up to support accurate identification or follow up support offered to SVA survivors disclosing to wider agencies.** | Coding practices proposed at both disclosure point and onward referral point. |
| **Some survivors may be facing barriers to disclosure.** | Communication around the way the disclosure will be handled and the new assessment process. |
| **Survivors and professionals have both reported mixed experiences of disclosure.** | As well as the training recommendations listed elsewhere, this will enable a consistent onward approach following the point of disclosure. |
| **These needs assessment analyses show there to be a gap between those estimated to have experienced SVA and those known to services.** | As above, better recording processes may improve the quality of the existing datasets, but also aim to improve access into onward specialist services if the process/pathway is made clearer. |
| **Commissioning of existing provision is fragmented and confusing.** | By implementing one consistent pathway, with agreed outcome measures. |
| **Professional agencies are not always working as well together as they could around the needs of the survivor.** | Completing one assessment should reduce the number of times a survivor has to 'tell their story' and the ongoing coordination role of the specialist agency would improve joint working across partners. |

The video below provides a summary of the recommendations that local survivors have proposed based on what they believe needs to happen moving forwards.

## Appendices

See separate document.

SVA JSNA appendices.docx

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