Comparing Sexual Assault Interventions project:

UK Case Study Report

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Purpose of this document

The *Comparing Sexual Assault Interventions* project aims to explore different models of intervention for female victims of sexual assault aged 16 and over across Europe, in order to develop recommendations for good practice and resources to build capacity and promote excellence. This document provides an illustrative case study of local service provision in the county of Merseyside in the United Kingdom, where sexual assault services are coordinated through the Sexual Assault Referral Centre (SARC) *SafePlace Merseyside*. The case study discusses the services available for victims of sexual assault in Merseyside within the context of national legislation, and provides details of inter-service coordination and multi-sector collaboration. Findings specific to the SARC are presented, triangulating input from national protocols and publications with perspectives from both the service provider and service users in an attempt to provide a complete picture that captures the complexity of sexual assault service provision. Having described the service in light of recommended standards and mechanisms for service provision, the paper brings together recommendations and implications for practice.

UK Case Study: Safe Place Merseyside

1 Background

In 2011/12, 53,665 serious sexual offences were recorded by the police in England and Wales.[1] Although steps are continually being made by police and other statutory bodies to foster greater victim confidence and subsequent reporting of sexual offences, indications are that only 11% of victims of serious sexual assault actually tell the police about the incident, with 38% of victims telling nobody at all about their experiences.[2] Survey data suggest that in 2011/12, 3% of women and 0.3% of men in England and Wales were victims of completed or attempted sexual assault.[3] Since the age of 16, it is reported that over 19% of women and 2.7% of men have suffered some form of sexual violence. When individuals do choose to engage with support services, the response of service providers to victims of sexual assault can have a significant impact on their receipt of appropriate care and later adjustment and recovery.[4 5]

Improving services for victims of sexual assault has become a key focus of government policy, following concerns around low rape conviction rates and poor coordination of victim services.[6-8] In England and Wales, a range of legislation, policy and guidance has been implemented to strengthen responses to sexual assault[9-13], including measures to provide immediate ongoing multiagency support and care to victims in order to limit the impacts of sexual assault and help secure convictions. The Government's existing action plan, *Call to end violence against women and girls: Taking action – the next chapter*[14], affirms the role of locally provided Sexual Assault Referral Centres (SARCs) in making healthcare, including forensic examination choices and the criminal justice system, more accessible to victims of sexual violence.

SARCs can be thought of as victim-centred medical units that aim to co-ordinate and simplify the pathway for victims of sexual assault, improve immediate care, aid recovery and boost conviction rates by supporting victims through the prosecution process. In 2012, there were 40 SARCs across England and Wales. The structure and delivery of SARCs varies, although services are typically delivered by a range of public, independent and third sector providers at premises owned by the police or the NHS in urban locations with high population densities. Leadership of SARCs at the regional level is provided by localised steering groups, which feed into a national steering group.

2 Methodology

Three sources of information were used to develop this case study:

2.1 Benchmarking and evaluation tool

A benchmarking and evaluation tool was used to conduct a structured face-to-face interview with the service provider. Two researchers were present at the interview, with one posing questions and the other taking notes. The tool was designed to assess service provision against a proposed set of standards derived from a literature review and mapping survey and consisted of sections on: (1) sexual assault-specific activities, coordination, efforts and response; (2) forensic services; (3) medical services; (4) psychosocial services; (5) police services; and (6) legal services. The service provider was asked to indicate whether a series of particular features were present, partially present, or not in place within the service. The interviewee was also given the opportunity to provide any additional service information not covered in the tool. The interview was conducted at the service's premises.

2.2 Policy documents, protocols, guidance for practice and official reports

Documentation and information readily available in the public domain was used to gain a wider understanding of the practice model for UK sexual assault referral services. Such information was used to verify, support and supplement findings established by the benchmarking and evaluation tool and was sourced online from the Home Office, National Police Improvement Agency (NPIA), Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS)[*].

2.3 Service user interviews

Whilst the information gained from the two approaches above can help to establish the mechanisms of provision and planning that exist and do not exist in a service, this may represent an 'ideal' that is not necessarily adhered to in practice or may not adequately meet the needs of all service users. Therefore the reflections of service users were sought to consider the effectiveness and suitability of the service from the client's perspective, identifying ways in which service provision may differ from the practice model but also allowing an exploration of what service users feel are the strengths and weaknesses or positives and negatives of sexual assault services available locally.

In an attempt to recruit female service users for interviews or focus groups, three different approaches were used, reflecting the organisations that clients may have contact with at various stages of their journey following sexual assault.

[*] The CPS is the Government Department responsible for prosecuting criminal cases investigated by the police in England and Wales and is involved in advising the police, reviewing cases, preparing cases for court and presenting in court.

Firstly, postcards providing brief details of the study were left at SafePlace Merseyside. Clients were encouraged to provide their details on the reverse of a card should they wish to take part in the study. A sealed box was provided for completed cards, with the researchers then able to contact any self-referred potential participants to arrange suitable interview times.

Secondly, extensive efforts were made to liaise with the two third-sector organisations providing local Independent Sexual Violence Advisor (ISVA) services (see page 12) in the hope that they could facilitate participant recruitment by highlighting the research to any of their clients who had utilised the services at SafePlace Merseyside. Although lengthy discussions were undertaken and detailed information was provided on the aims and objectives of the research, the university's ethical approval process, the need for service user input and the nature of interview topics, it was not possible to access clients via this route. One ISVA service failed to return contact and the other was unwilling to assist as they felt that it would never be possible or appropriate to speak with SARC clients who were so recently traumatised and stated that they would be failing in their duty of care if they supported access to them. The ISVA service expressed concerns that service users should not meet one another and suggested that the only way to gain any input from the service users' perspective would be to ask the ISVAs themselves to provide feedback on how clients feel and perceive the levels of service and care. Although the ISVA service initially passed on some negative feedback from one of their advisors, contact thereafter was limited and the research team felt that ISVAs were not an appropriate proxy for service users in this context.

The final approach involved contacting the following local community organisations and asking them to display a poster in their foyer or communal areas advertising the study: a women's refuge, a domestic violence service, a black minority ethic women's group, a charity supporting victims of crime, an organisation running women-only centres, a local authority vulnerable victims advocacy team, an independent advice service and a student wellbeing/counselling service. The poster provided basic study details and a contact address, email address and telephone number for the research team. When initial contact was made, organisations were provided with a more detailed explanation of the aims of the work, the ethical considerations and the importance of focus groups or interviews with service users. The poster was attached in an email but an offer was also made to send a hard copy to avoid the incurrence of printing costs for the organisation. Despite numerous follow-up calls and emails, confirmation was however only received from one organisation that the poster had actually been displayed and no responses were received.

Responses to the above approaches were very limited as services were generally extremely reluctant to support research that involved service users. It therefore proved difficult to reach target populations that were considered likely to include clients of SafePlace Merseyside once they had left the service. Three clients did, however, complete contact cards at the service itself, and were subsequently contacted by the research team. Two

clients confirmed their desire to take part in the research and were invited for individual interviews. One client was no longer available on the contact details provided.

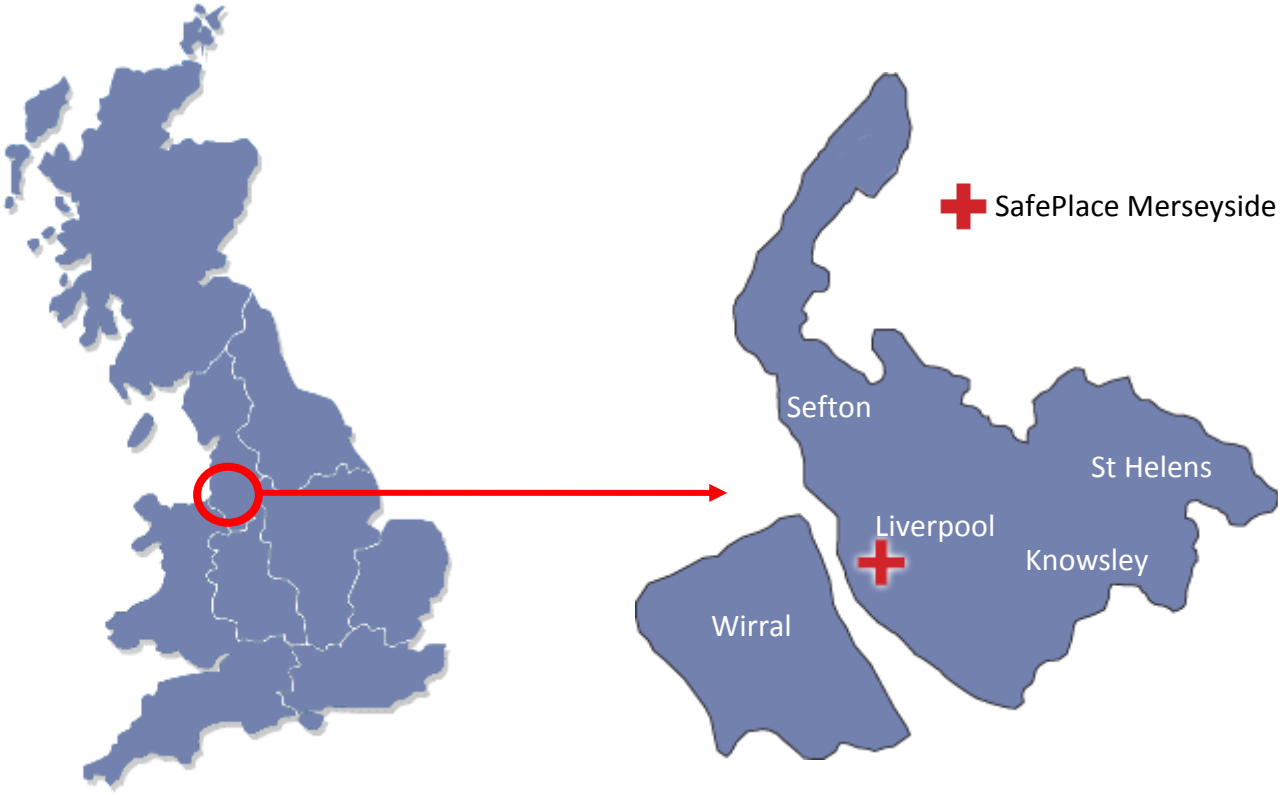
Although arrangements were made with the two clients to hold interviews at times suitable to them, transport to and from the interview was arranged with the safe taxi service used by SafePlace Merseyside, and clients were given the option of having a counsellor either present during the interview or available after should they require a debriefing session, neither client attended their scheduled interview. Despite numerous attempts, researchers were unable to make contact with the clients again.

Due to the outlined difficulties in approaching and interviewing service users, service user interviews were supplemented with input from anonymous Patient Experience Surveys (n=29) that had been collected by SafePlace Merseyside during the first two quarters of 2012.

3 Sexual Assault Services in Liverpool, UK

Liverpool is home to one of the UK's 40 SARCs, named SafePlace Merseyside. Situated in the city centre, SafePlace Merseyside was established in 2008 and serves a core population of around 1.3 million Merseyside residents, covering the five metropolitan districts of Knowsley, St Helens, Sefton, Liverpool and Wirral. With a high rate of tourism in and around the city, three large universities and an established nightlife scene, the SARC also serves a transient population of tourists, students and those visiting the area for business or leisure (e.g. stag and hen parties). All services provided by the SARC are fee-free, as are psychological and practical services. For legal services, free court assistance is provided by the Witness Service and cases are prosecuted by the Crown.

Figure 1: Location and coverage of SafePlace Merseyside



SafePlace Merseyside forms part of a co-ordinated model of sexual assault service provision, which provides forensic and medical services and 'contracts out' psychosocial services to local Independent Sexual Violence Advisors (ISVAs) (see section 4.2) working for third sector organisations. Co-ordinated by two full time staff members, the centre is accessible 24 hours a day throughout the year and has 19 on-call crisis workers who together support around 200 service users annually. This figure has risen steadily over previous years as the

service has developed and such growth is predicted to continue. The service serves both females and males although 95% of attendees are by female.

Although SafePlace Merseyside will not accept referrals for individuals who are suffering from serious injuries as the centre and its staff are not equipped to provide specialist medical treatment beyond basic first aid, staff may be called to attend at locations such as hospitals or care homes and do so with a mobile examination kit ('grab bag'). Remote support is provided in line with protocols and processes that exist at the SARC and clients are given the option of referral to an ISVA service. Although Liverpool hosts a specialist children's SARC based in Alder Hey Children's Hospital that provides sexual assault services for those under the age of 16, SafePlace Merseyside will take referrals for teenagers in certain situations where an adult-oriented service is considered more appropriate.

SafePlace Merseyside combines the expertise and services of health professionals and the police, who work with coordinated protocols, practices and reporting processes that have been agreed upon by all sectors and agencies engaged in providing sexual assault-related services. Such protocols encapsulate reporting mechanisms for sexual assault cases and confidential information sharing, client flow and referrals through sectors, as well as ethical and safety standards for coordination.

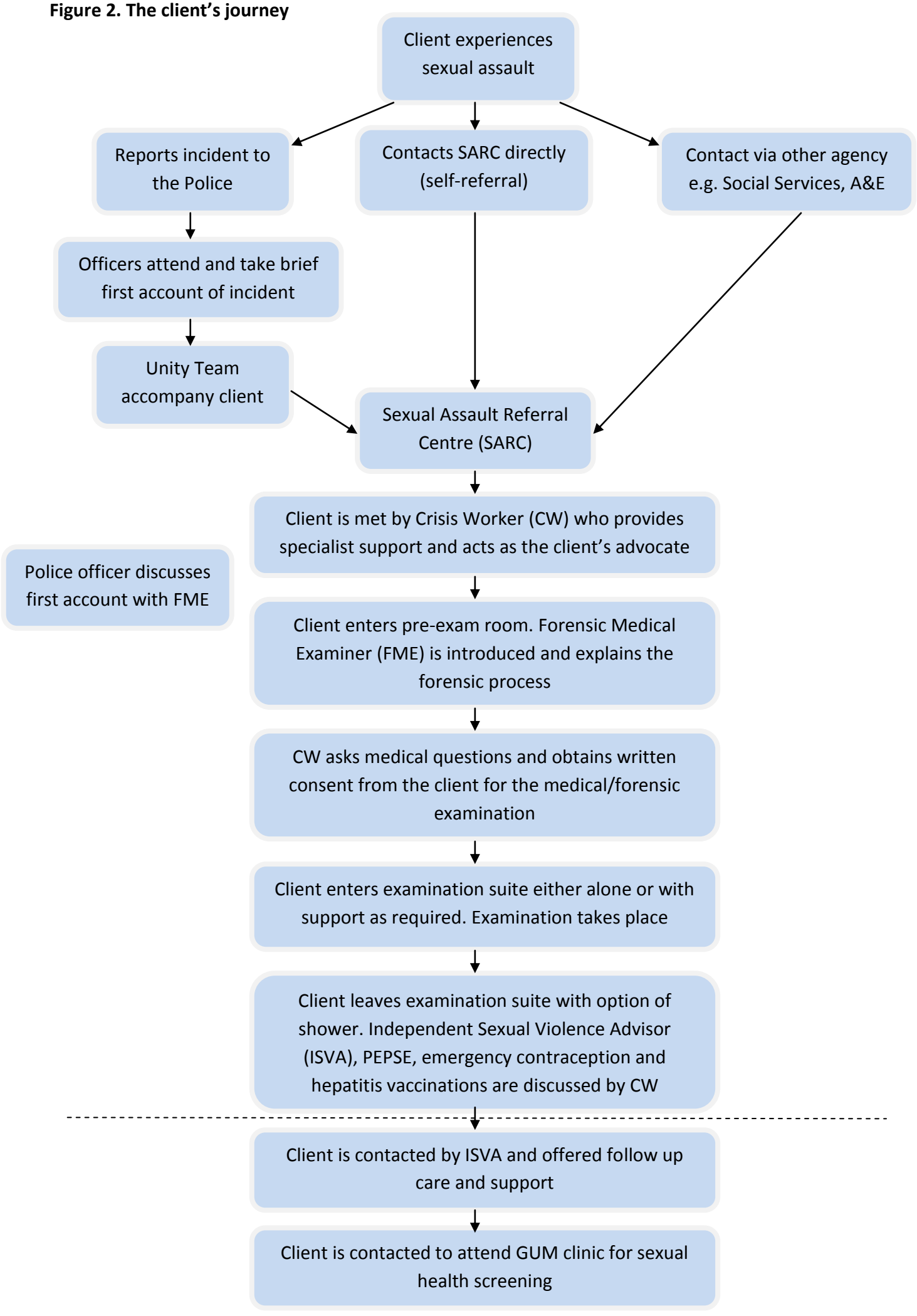
4 The client's journey

Figure 2 shows the client's journey when accessing sexual assault services in Liverpool. If an individual reports a sexual assault to police, health services or other social services in Liverpool, they will be referred to SafePlace Merseyside. Clients may also self-refer, and information and the telephone number for the service is disseminated via awareness raising materials in public places. However, the physical location of the service is not advertised to ensure confidentiality for those visiting the service. A manager or administrator is present at the service to answer the phone during office hours and outside of these times callers will be connected to an operator service that will then have a crisis worker (CW) call them back as soon as possible. CWs must adhere to a strict procedure when taking self referral calls and do so using a Crisis Worker Toolkit (a folder containing important information on safeguarding, mental capacity assessment, additional support services, client transport, lone working, conflict resolution and self referrals) and a telephone call log sheet. The CW will ask the client how they can help, but ensure that they explain the limits of confidentiality, particularly in relation to safeguarding issues.

If an individual reports a sexual assault to police, they will be taken to SafePlace Merseyside by a specially trained police officer known as a Sexual Offences Liaison Officers (SOLO; see section 4.3). The SOLO will take a brief account of the incident (including details such as who, what, where and when), and will brief the doctor at SafePlace Merseyside prior to the victim's medical examination. A videoed police interview needed to cover the incident in

fine detail will take place two to three days later at a police-owned house in a location away from the individual's place of residence, for the purposes of confidentiality. Individuals who are referred to SafePlace Merseyside by other agencies, or who self-refer, can choose whether or not to report the incident to the police (see Box 1).

Figure 2. The client's journey



Box 1. Reporting of sexual assaults to the police

Clients attending SafePlace Merseyside are not required to report the incident to the police. However, with consent, the service can collect forensic evidence and verbal information from the client that can be held at the SARC typically for six months and made available should she wish to pursue criminal justice processes at a later point in time. Clients may also choose to provide information about their assault to the staff at the SARC, who can then pass this information on to the police anonymously. This can provide the police with key intelligence that could help to prevent future attacks.

On arrival at SafePlace Merseyside, the client is met by a Crisis Worker (CW) who provides specialist confidential, emotional and practical support and acts as the woman's advocate during her time at the service. If a friend or a relative has attended the SARC along with the client, the CW will initially try to get the client alone to talk through the examination process and services provided by the centre. The friend/relative may, however, stay with the client during the examination if desired. Throughout the client's journey, waiting times are limited wherever possible. Both on-call CWs and doctors are required to be in attendance at the SARC within 30 minutes of receiving a call out and clients must be seen within 60 minutes of the time of referral. A longer wait may be incurred if the client is intoxicated or if another client is in the examination suite. The CW must ensure that the client can understand and speak English well enough to give informed consent to the examination, otherwise an interpreter should be called. The CW will also complete a safeguarding checklist for the client and may be required to contact the Safeguarding Adults Team within Liverpool Community Health (NHS).

In a designated pre-exam room, the CW will introduce the client to the doctor who will be conducting the forensic medical examination. Examinations take place in a dedicated examination room (see section 4.1) and are conducted by specialist doctors (Forensic Medical Examiners; FMEs) who can also provide emergency contraception, vaccinations, post-exposure prophylaxis (PEPSE)[†] and referral to sexual health clinics. Once the FME has given details of the forensic process to the client, the CW will take the client's medical history and obtain written consent for the examination. The client will then enter the examination suite with the FME, the CW and other support as required. If the client has been referred to the SARC by the police, the SOLO will be present in the examination suite to ensure the chain of evidence and forensic integrity, but will remain behind a closed curtain at all times. During the examination, the FME will examine all parts of the client's body and may take specimens such as swabs or blood and urine samples. The client will be asked to give more precise details of her experience to the FME who will conduct a risk assessment for self-harm.

[†] PEPSE is a treatment that can stop a person becoming infected with HIV after it has entered the body.

Upon completion of the examination, the client leaves the suite and is given the option of a shower and a change of clothes. In the post-exam room, the FME, the CW and the client are then able to sit down and discuss contraception options and other medical treatment such as PEPSE and vaccination for Hepatitis B. If the client is given either form of medication, written information is also provided detailing dosage, potential side effects etc. The CW will ask the client for their signed consent for referral to an Independent Sexual Violence Advisor for continued advice and support (see section 4.2). The preferred method of contact and telephone number(s) will be verified and the CW will check that the client is in possession of their mobile phone (if this is the preferred means of contact). An ISVA is required to contact the client within 24 hours of their attendance at the SARC (excluding bank holidays). For screening and treatment for sexually transmitted infections, clients are referred to a local Genitourinary Medicine (GUM) clinic for follow up, as infections may not be identifiable until up to 14 days after exposure. Suitable transport will be provided for clients to leave the SARC and travel home.

There may be certain occasions when a client in unable to return to their home if it is the scene of a crime and alternative accommodation cannot be accessed immediately. Clients may rest for a short period on a bed settee located in the administration office at SafePlace Merseyside and will be provided with pillows and a duvet. On such occasions, the FME will remain in the SARC until the client is able to leave safely.

Once a client has left SafePlace Merseyside, the support and guidance provided by an Independent Sexual Violence Advisor is ongoing and may continue for as long as is deemed necessary. In cases that go to court, an ISVA will provide support through the criminal justice process and will work alongside the Witness Service to communicate the client's needs and arrange special protection measures in court as required.

5 Specific service provision

This section provides further information on the different aspects of services provided throughout the sexual assault referral centre model in Merseyside.

5.1 Forensic and Medical Services

Forensic medical examinations are available at SafePlace Merseyside 24 hours a day and are carried out in privacy in a dedicated forensically-approved, cleaned and sealed room. A colposcope is available with appropriate storage for images. Examinations are undertaken by Forensic Medical Examiners (FMEs) - doctors who are specially trained to deal with sexual assault interventions. Clients have the right to choose whether to be seen and treated by a male or female doctor. Examinations are carried out in a uniform way, with clients seen within 30 minutes to an hour.

Protocols for performing forensic examinations are outlined by the Faculty of Forensic and Legal Medicine at the Royal College of Physicians (FFLM), a charity set up to maintain the highest possible standards of competence and professional integrity (see www.fflm.ac.uk). Alongside national guidelines for conducting forensic examinations, standard evidence collection kits and pro formas are used. Mechanisms are in place to ensure that the client gives full informed consent for the forensic examination process (both before and during). The Crisis Worker discusses the examination process and obtains consent from the client before they enter the examination room. They will then accompany the client during the examination to raise the client's concerns should they wish to stop at any time or withdraw completely. Full client records are generated within 48 hours. These become the property and responsibility of the FME and must meet the confidentiality and information governance requirements of the police and the NHS. If authorised by the client, information may be shared with the police and community services as appropriate. FMEs may then also be called upon to testify in court.

Written information is available to service users regarding the preservation of forensic evidence, both in leaflet form and contained within the *frequently asked questions* page on the SafePlace Merseyside website (www.safeplacemerseyside.org.uk). Additionally, advice can be sought by telephone and clients are able to speak to a Crisis Worker 24 hours a day, 365 days of the year. A telephone number is also provided on the website for individuals who may require this or any other information in a different language.

Within their training FMEs are sensitised to the needs of different population groups. At SafePlace Merseyside, this sensitisation is supported by a variety of special measures to cater for these populations, from cultural issues training and translation services to a fully equipped wet room and hoists for disabled service users. A directory of services and organisations is maintained and used for referrals. This includes organisations in the third sector specialising in support for young people, victims of domestic violence, and ethnic minority groups.

Within what is referred to as the 'modern forensic movement', forensic services are overseen by a Principal FME employed by Merseyside Police Authority. The Principal FME's responsibilities include attending management meetings within the force, ensuring adequate cover and identifying training needs. New FMEs spend a period of time shadowing the Principal FME, observing and assisting on tasks in accordance with a predetermined training syllabus. Each new FME is required to complete a minimum number of particular types of examination before being allowed to operate independently and it is the Principal FME's responsibility to certify that an acceptable standard has been reached. As with all disciplines of medicine, continuous professional development is core to the practice of FMEs and training takes place annually. Revalidation (a formal system for ensuring that doctors remain fit for practise) also occurs every five years through recommendation to the General

Medical Council (GMC) on the basis of five consecutive satisfactory annual performance appraisals.

5.2 Psychosocial and practical services

Although crucial support is provided at the SARC by Crisis Workers, once the client has completed their forensic examination and left the centre, psychosocial and practical services are provided by an Independent Sexual Violence Advisor (ISVA), communication with whom is set up by the SARC. ISVAs are victim-focused advocates who are funded to work with victims of recent or historic sexual crimes and enable them to access the services they need, depending on the client's individual circumstances and requirements. Using a standard reporting form, ISVAs conduct an assessment of the client's risk of self-harm, symptoms of Post-Traumatic Stress Disorder (PTSD), symptoms of depression, anxiety and low self-esteem, need for a refuge or safe house, and need for childcare or the involvement of Social Services. This information is used to develop a bespoke care plan for the client. ISVAs must document all actions and maintain confidential client files, sharing information with the police and community services where appropriate and authorised by the service user. A client's relationship with their ISVA may continue for weeks or months after an assault, with individuals often receiving support for up to 18 months, particularly when criminal justice proceedings are taking place. The role of an ISVA is multifaceted and includes providing information about the criminal justice system, support and advocacy through the criminal justice process, information and advice about health needs and options, emotional support and/or support to attend related appointments, and referral to other services or agencies. The ISVA may then act as a point of liaison for all other agencies involved with that client. A recent independent review of how rape complaints are handled by public authorities in England and Wales, commissioned by the Home Office (The Stern Review)[1], served to highlight the importance of ISVAs, considering them an 'intrinsic part' of the way rape complainants are dealt with. Up to 2015, funding from the Home Office has been made available at a rate of £1.72m per annum to support ISVAs working in the voluntary and community sector and in SARCs themselves[16].

Skills for Justice (an independent UK wide organisation that exists to tackle the skills and productivity needs of the justice, community safety and legal services sector) has recently worked in conjunction with the Home Office to develop a set of National Occupational Standards for ISVAs. In Merseyside, all ISVAs are accredited practitioners who have undertaken training that encompasses planning and protection, building and maintaining effective partnerships, effective communication, diversity and equality, and actions in court and beyond. As well as this sensitisation to the needs of different populations, specialist ISVA services exist for sex workers and Merseyside has recently seen the introduction of its first male ISVA. As well as sensitising other sectors on sexual assault through their advocacy of victims, ISVAs also work to sensitise the public through social marketing and campaigns for vulnerable or marginalised groups such as adolescents, ethnic minority women and sex

workers. ISVA services are overseen and monitored by the Home Office whose quarterly reports evaluate service provision quality and service user outcomes.

Although there is currently no requirement for ISVA services to be available 24/7, it is reported that generally in Merseyside an ISVA's phone will always be on and there is an unwritten understanding that clients may call whenever they feel they need support. Due to a purported lack of services and support in Merseyside for the families, friends and partners of women who have experienced sexual assault, ISVAs do offer support that extends beyond the client, although this is by informal arrangement only and is not within their official role prescription.

5.3 Police services

The police have a series of comprehensive protocols for both preventing and responding to sexual assaults. Guidance on investigating and prosecuting rape is produced by the National Policing Improvement Agency (on behalf of the Association of Chief Police Officers and the Crown Prosecution Service) and applies to all police involvement, from initial contact (with telephone operators) to first response and criminal trials. Overall this guidance reiterates the premise that victims should receive a 'seamless service' between police, the Crown Prosecution Service, health services and specialist sexual violence services[13].

The multidisciplinary and collaborative nature of sexual assault service provision in Liverpool is exemplified by the innovative Unity Team that was formed by Merseyside Police in 2010. The first of its kind in the UK, this dedicated sexual assault investigation team brings together specialist detectives from the police force and expert rape lawyers from the CPS in one unit, allowing allegations to be dealt with and offenders brought to court more quickly, whilst simultaneously enabling early decision making regarding how best to support victims in court. To ensure that the specific needs of victims of sexual assault are met, some police officers are specially trained for a role as a Sexual Offences Liaison Officer (SOLO). SOLOs will, in the case of incidents reported to the police, accompany a victim to the SARC and act to ensure the chain of evidence and forensic integrity. SOLOs are briefed in recognising post traumatic stress disorder and cognisant of the difficulties victims are likely to face when describing their experiences. Through the National Policing Improvement Agency Specially Trained Officer Development Program, all individuals tasked with the SOLO role are extensively trained in the Sexual Offences Act (2003), interview and investigative procedures for sexual assault, and risk and safety planning for victims, with a focus on those who are vulnerable due to disability, incapacity, location and opportunity. A SOLO will typically assume a coordinating role in communicating with the victim, although the victim is given the option of being updated by the SOLO, the investigating officer (IO) or an ISVA.

Reports of all crimes under the Sexual Offences Act (2003) are graded to receive an immediate response, unless the victim is reporting an event that took place some time ago (and immediate forensic opportunities do not exist). Ensuring there is no delay in police

contact with the victim or further sources of evidence should work to prevent any potential loss of evidence. Minor response delays may occur as a result of considering the wishes of the victim - if they do not want a visible police response or are specifying where and when they would like police contact for example - but police services are available 24 hours a day, seven days a week. Whilst female victims will always be provided with same-sex officers trained in sexual assault response, this is not the case for male victims as all SOLOs in Merseyside are female.

At first contact with the victim, a SOLO will ensure the victim's welfare and medical needs are met and take a first account of the incident, whilst a fellow officer will assess the scene and preserve any forensic evidence using an early evidence kit. The SOLO will then ask the victim to accompany them to SafePlace Merseyside for a forensic examination. Colleagues may remain at the scene. If the victim refuses the examination, referral information can be provided for medical aftercare, victim support and counselling. According to the Victim's Code (see section 4.4), police must ensure that victims can access information about local support services (including contact details) as soon as possible after an allegation is made, and no later than five days from the first contact. Information must be provided in a language and format that the victim can understand. In accordance with the Victim Referral Agreement, in cases of sexual offences (as is also the case for domestic violence but unlike other crimes against the person), the police pass the victim's contact details on to Victim Support[‡] only when the victim gives explicit consent for them to do so.

The victim's first account is taken with a series of pre-established questions[15] and the SOLO will begin an investigation log. All reports of sexual assault are recorded in compliance with the Home Office National Crime Recording Standards[16]. Private interviewing spaces are provided in discrete police 'houses' in the case of follow-up video interviews. The timing of these interviews is decided in consultation with the victim, giving some control back to the victim and maximising the potential for recall. In the case of victims presenting to police stations, private on-site interview spaces are provided for gathering initial information.

5.4 Legal services

Legal services for sexual assault cases are provided in Merseyside by the Unity Team. As a unique working collaboration between the police and the Crown Prosecution Service (CPS), this service provides specialist support in line with a joint national protocol for the handling of rape cases. Co-ordination of investigation and prosecution between these agencies is overseen regionally by a CPS-appointed Area Rape Coordinator. The CPS also provides a network of rape specialist prosecutors who have a responsibility for cases of sexual assault from pre-charge to case conclusion. These specialists are barristers who have completed a CPS accredited course for undertaking rape prosecutions in court, during which they are

[‡] Victim Support is a national charity that gives free and confidential help to victims of crime, witnesses, their family, friends and anyone else affected across England and Wales (www.victimsupport.org.uk).

taught about the myths and stereotypes surrounding sexual assault and the emotional and psychological effects of rape. As soon as possible following the initiation of criminal justice proceedings, the specialist prosecutors will conduct an early consultation with the police, conduct pre-trial interviews with the victim and any witnesses, arrange special measures for giving evidence in court (if necessary for the victim's protection) and work with the police and the courts service (HMCS) to ensure that the victim and witnesses are kept informed as to changes to the bail conditions or custody status of the accused person. Rape specialists then work closely with the investigating officer to build the case for the prosecution, using the Rape Prosecutions Advice/Review Checklist to explore all possible avenues of evidence. Only certain Judges are authorised to hear rape cases. These Judges must have attended a 3-day training course that is renewed every three years.

In working with victims of sexual assault, the police and the CPS must both comply with the responsibilities set out in the Victim's Code. This code represents a minimum level of service and obligations for information sharing for all organisations involved in criminal justice, from the CPS and HMCS, to the police, the Prison Service and the Probation Service. Special consideration is given in the code to vulnerable or intimidated victims. The code also dictates the provisions required of CPS Witness Care Units (WCUs), including court familiarisation visits for victims and additional assistance for non-English language speakers and those with accessibility requirements. At this point, and throughout the legal proceedings, an ISVA may assist in communicating the victim's needs to the CPS. As a result of the specialist services provided by the Unity Team, legal proceedings are conducted with minimum delays, typically within six months. The CPS may request special measures for any victim in court. If granted, this may allow the victim to provide evidence via a videotaped interview, whilst concealed behind a screen, or with greater privacy (i.e. with everyone vacated from the public gallery). Decisions regarding such measures are at the discretion of presiding Judge.

6 Service delivery

This section provides a summary of the structures and activities that allow multiple agencies in Merseyside to collectively address all the dimensions of care and support needed by victims of sexual assault.

6.1 Coordination

The regional steering group that oversees the Liverpool SARC and coordinates and monitors inter-agency and multi-sector work is health-service led, although this is an 'informal' arrangement that has been assumed over time (the chair of the group is the manager of the first ever SARC, established in Manchester in 1986) and leadership varies across different UK regions. In Merseyside, to maintain a high standard of collaborative work, meetings with all sectors are organised every quarter in the form of the police-led Harm Reduction Forum.

Although different agencies do not meet to review individual cases, the forum provides an opportunity to discuss issues surrounding service provision and is complimented by quarterly service planning meetings held by the Strategic Management Group. It is strongly felt within the service provision network in Merseyside that official platforms for case review are not necessary as there is routine coordination between all agencies. If necessary, serious case reviews are held by the police for intelligence sharing, for example in the case of a suspected serial rapist.

6.2 Staff training

Service coordination is additionally supported by multi-disciplinary training that also takes place every quarter. During these evening sessions, which are attended by ISVAs, medical practitioners, crisis workers and representatives from the police, reflective practice is explored and guest speakers are invited to talk on issues relating to sexual assault and addressing the needs of service users (e.g. cognitive dissonance in violent and abusive relationships). The SARC also conducts additional sexual assault awareness training with ambulance drivers and Accident and Emergency department staff that advises on the preservation of forensic evidence and sensitises staff to the needs of victims.

6.3 Commissioning

SARC services are commissioned by local authorities and primary care trusts, with funding from the police and centrally from the Home Office. For SafePlace Merseyside, applications for funding are made collaboratively and are led by a health-based lead commissioner from the Primary Care Trust of one of the five metropolitan boroughs (Wirral). Although in recent years sufficient funding has been available to plan sexual assault services across relevant sectors for the short and often medium term, national structural changes are currently placing a limit on such certainty and security. In particular, the potential impact of the incoming Police and Crime Commissioners (due to be elected in November 2012) and the move for Forensic Medical Examiners (FMEs) from employment within police authorities to positions within health services are of note (see Crilly et al, 2011[17]).

6.4 Evaluation

The SARC regularly conducts evaluations in the form of patient user experience questionnaires which are used to develop and implement new action plans. The questionnaires are anonymous and are made available in many different languages. Questions focus on the quality of service provision, including whether or not the treatment was explained in a way that was understandable, whether or not the client felt fully involved in decisions about their treatment and care, if the client felt they were treated with dignity and respect, and how they would rate their overall experience. Additional space is provided for any further comments or suggestions clients may have. During the service provider interview, the manager of SafePlace Merseyside highlighted a recent example of an action

resulting from this client feedback. Having received a questionnaire that raised concerns about the visibility of drugs prescribed at the SARC, clients are now provided with an unlabelled bag in which they can conceal any medicines or leaflets when they leave the centre.

Activity within the SARC is also measured quarterly, with data including the total number of clients attending, the number attending for specific services only (e.g. forensic only or follow up services only), the key demographics of clients (gender, age, ethnicity and sexual orientation), the referral source for clients, the assault location and their relationship with the assailant. Clinical information is compiled to monitor the proportion of clients who are prescribed PEPSE, the duration of forensic examinations, the number of criminal justice statements provided and the number of clients requesting or requiring psychological or counselling services.

Data collected by the SARC and Merseyside Police concerning the prevalence of sexual assault are routinely compared to those reported by the Crime Survey for England and Wales (formerly known as the British Crime Survey). Local data from other services (e.g. the ambulance service) are also considered to establish rates of referral between services.

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7 Perceptions of the service provider

Whilst much of the information above concerning service provision and the client's journey was identified during an extensive interview with the service provider, the following section serves to highlight some additional key points that were communicated by the manager at SafePlace Merseyside when reflecting on the standards of care and the efficiency and suitability of the SARC model.

When interviewed, the manager of SafePlace Merseyside was confident that their service works well with other services that provide support for victims of sexual assault. This is a belief that had been affirmed by the recent receipt of an award for collaboration from a local PCT. It was therefore reported that great achievements have been made and no additional improvements are required. This purported excellent collaboration was largely attributed to a common ethos of shared ideals and an overriding commitment to the cause in each individual involved in service provision. Individuals choose to apply for specialist police roles and whilst there is limited monetary reward, it is through exceptional drive and motivation to give something back and make a difference that individuals from a wide range of backgrounds are said to put themselves forward for these and other relevant positions, such as crisis workers. For many roles, additional training is required and in the case of ISVAs in particular, the individual themselves may have to make an additional investment in paying to train and to gain accreditation. For those performing on-call roles, other

employment is maintained and duties as a FME or Crisis Worker are undertaken often during antisocial hours and in what would typically be personal or free time.

Among those agencies involved in service provision, information sharing practices are said to have been designed to limit the immediate impact on clients. Once the client has given a detailed description of her experience to the FME during examination, the doctor produces notes that are subsequently passed over to the ISVA to limit the number of times a woman has to give a detailed description of her experience. This negates the need for the client to retell the same information to their ISVA and supports inter-service coordination.

The manager of SafePlace Merseyside was also keen to highlight the ways in which feedback from and cooperation with other follow-on services allows the SARC to respond to engagement or retention issues and client needs. For example, as a result of clients failing to attend follow up appointments, SafePlace Merseyside has recently implemented a system by which clients can opt to have the GUM clinic contact them after a suitable time interval and are then provided with a taxi service to and from the resultant appointment.

Numerous examples were provided of the renown of SafePlace Merseyside, both nationally and internationally. The service is frequently visited by managers and staff from other SARCs across the country who are thought to look to the procedures and protocols at SafePlace as a demonstration of best practice. Keen to support the establishment and development of other centres, the manager at SafePlace Merseyside readily shares both ideas and materials with her counterparts. The SARC has also played host to many international visitors, including forensic medical practitioners from Saudi Arabia and the Turks and Caicos Islands. The staff at SafePlace Merseyside felt that these visits were instrumental in allowing the cross-cultural exchange of ideas.

8 Perceptions of service users

8.1 Patient Experience Surveys

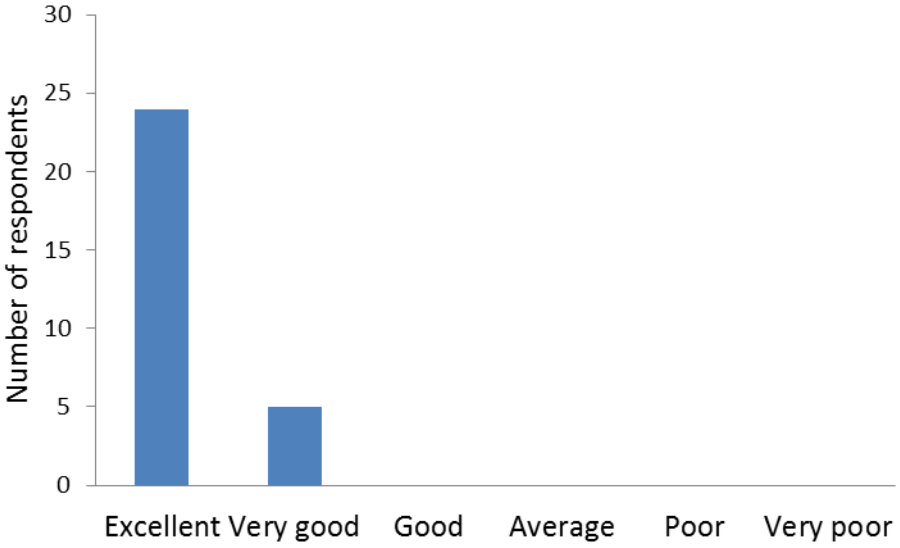
During the first two quarters of 2012, clients at SafePlace Merseyside were invited to take part in survey developed by Liverpool Community Health (NHS). The survey was anonymous and asked clients questions about the quality of service they had received and whether they had any comments or suggestions for service improvement. Of a possible 82 clients who underwent forensic medical examinations during this period, the survey was completed by 29 respondents (35% response rate).

All respondents indicated that the health professionals at the SARC explained their treatment to them in a way that they completely understood and all felt they were as involved as they wanted to be in decisions concerning their treatment and care. All respondents reported that such discussions regarding their condition and treatment were held in private and confidential surroundings. The vast majority of clients completing the

survey said they were treated with dignity and respect and had continued confidence and trust in the clinical staff treating them (93.1%). Respondents confirmed both that written information about their care and treatment was provided to them (93.1%), and that they were told who to contact if they had any worries, fears or questions regarding their condition (96.6%). Of those respondents who reported being on medication, 96.6% said they were told about possible side effects to look out for.

Generally respondents reported that they knew how to make a compliment about the service (82.8% said yes they knew) but were more unsure about how to make a complaint (55.2% said yes they knew), with eight individuals declining to answer the latter question. All respondents said that they would recommend the service to their friends, family members or colleagues. Ratings of respondents' overall experience are illustrated in Figure 3 below.

Figure 3. How would you rate your overall experience of the service?



When given the opportunity to make additional comments, one respondent reported feeling "constantly reassured", one noted the "pleasant and relaxing surroundings" and a third respondent described her doctor as "second to none".

9 Recommendations

In the absence of direct communication with service users, it is difficult to determine if the attitudes presented by staff involved in service provision are also supported by service users themselves and if information regarding the effectiveness of service provision and coordination is an accurate reflection of the support provided to victims. Nevertheless, having spent a substantial amount of time exploring the service model and considering forensic, medical, psychosocial, police and legal services independently as well as looking at overall multi-sectoral and interagency coordination, it is possible to put forward the following recommendations for increasing the effectiveness, appropriateness and humanity of sexual assault services, with the caveat that input from service users should be sought when considering any changes to the services that are currently available or the way in which services are delivered and coordinated.

9.1 Sexual assault services in Liverpool

Although there is a very good working relationship and referral process between SafePlace Merseyside and the organisations that provide local ISVA services, there is a reported lack of understanding as to the role of ISVAs among police forces both locally and nationally. This has particular implications for those individuals who are sexually assaulted in areas beyond their area of residence (i.e. outside of Merseyside), do not attend the SARC, and should subsequently be referred by other police forces to ISVA services within Merseyside. It is imperative to ensure that all police forces across the UK are aware of the aims and scope of ISVA services, the support and guidance they can offer, and the referral mechanisms for victims, particularly as these services are central to the government's plans for future sexual assault service provision. To foster understanding and cooperation across county borders, an ISVA service should first work with their local police force to raise awareness among police staff, challenge any misconceptions and address any barriers to coordination. Meeting and talking to an ISVA could, for example, become a key part of the training programme for new officers.

Throughout discussions with all relevant service providers in Liverpool, concerns were raised surrounding the availability of support for the families and close friends of victims of sexual assault. Although the manager at SafePlace Merseyside indicated that extended support is sometimes provided on an informal basis by a victim's ISVA, discussions with a member of staff from one ISVA service clearly indicated that the current demands for their time are such that individual ISVAs may have up to 50 clients at any given time, significantly limiting their ability to provide any services beyond those which they are formally contracted to. As there is a significant body of literature outlining the profound impact that sexual offences can have beyond the individual victim, it is important to ensure that all those affected this

type of crime receive the support that they need, particularly as concerns for the welfare of friends and relatives may factor into an individual's decision to report or seek help following a sexual assault.

It is recommended that additional services are also established to provide specialised psychosocial and counselling support to victims from the lesbian, gay, bisexual and transgender (LGBT) community, as this was identified as a particular need by the manager at SafePlace Merseyside. Although there are services elsewhere in the North West for gay men who have experienced sexual assault (e.g. see www.survivorsmanchester.org.uk), there are no such services in Liverpool and lesbian women are particularly overlooked. To establish services that meet the needs of homosexual men and women, it will be important to consult with individuals from these target groups to identify ways in which their treatment and support needs may differ from those of heterosexual victims.

The most pervasive conclusion that can be drawn from this exploration of service provision in Merseyside is the need for additional local (and national) research activities. First the issue of how to access service users needs to be considered. This issue is somewhat two-fold as implementation of the proposed methodology for this case study has demonstrated that is it extremely difficult to: (a) reach service users to provide them with details of research studies and opportunities for them to give their feedback, and (b) engage with those individuals who are initially contactable. Key research questions would include: when is the best time to approach victims; who should approach them and by what means; and how should they do this to ensure that the victim is as comfortable as possible and able to make an informed decision as to whether or not to take part in the research. Any such advances may need to be predicated on cultural changes that allow organisations within the sexual assault service model to understand the value of research activities and the desire of researchers to empower victims of sexual assault through their inclusion.

The benefits of SafePlace Merseyside, the Unity Team and ISVA services could be grounded in research evidence with the compilation of data on reporting and conviction rates. As well as establishing how victims perceive the effectiveness, appropriateness and humanity of sexual assault services, the SARC model provides a valuable opportunity to look at which victims chose not to report to the police and their reasons for doing so. Information such as this may assist the police in developing ways of increasing reporting behaviour. Data should also be collected and analysed to look at both the referral rates of sexual assault victims to SafePlace Merseyside, and the onward referral of SafePlace clients to ISVA services. One ISVA service in Liverpool raised concerns that there may be a considerable drop off in service engagement post SARC, and it would therefore be very useful to identify whether this is the case, why these individuals are disengaging, and what could be done to foster greater engagement with support services.

9.2 Transferable learning at the European level

Producing a case study of sexual assault services in the UK using the benchmarking and evaluation tool has allowed the identification of many key learning points that may help to support the development and enhancement of services elsewhere in Europe. In order for this information to be used most effectively however, it is important to supplement current understanding (as identified in the sections above) with information on the resource implications and requirements of such a model of service provision. Financial considerations would include the costs of both setting up and maintaining the SARC model (including facilities and equipment, staffing and staff training), alongside the potential cost savings derived from a coordinated model and its impact on prosecution rates, long term medical care and psychosocial support etc. To provide a realistic picture to partner countries and other interested parties within the European Union, further work should consider the cultural and political requirements for bringing about substantial change and introducing a model reliant on multi-sectoral collaboration, drawing on the experiences of those who have helped to achieve this in the UK.

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