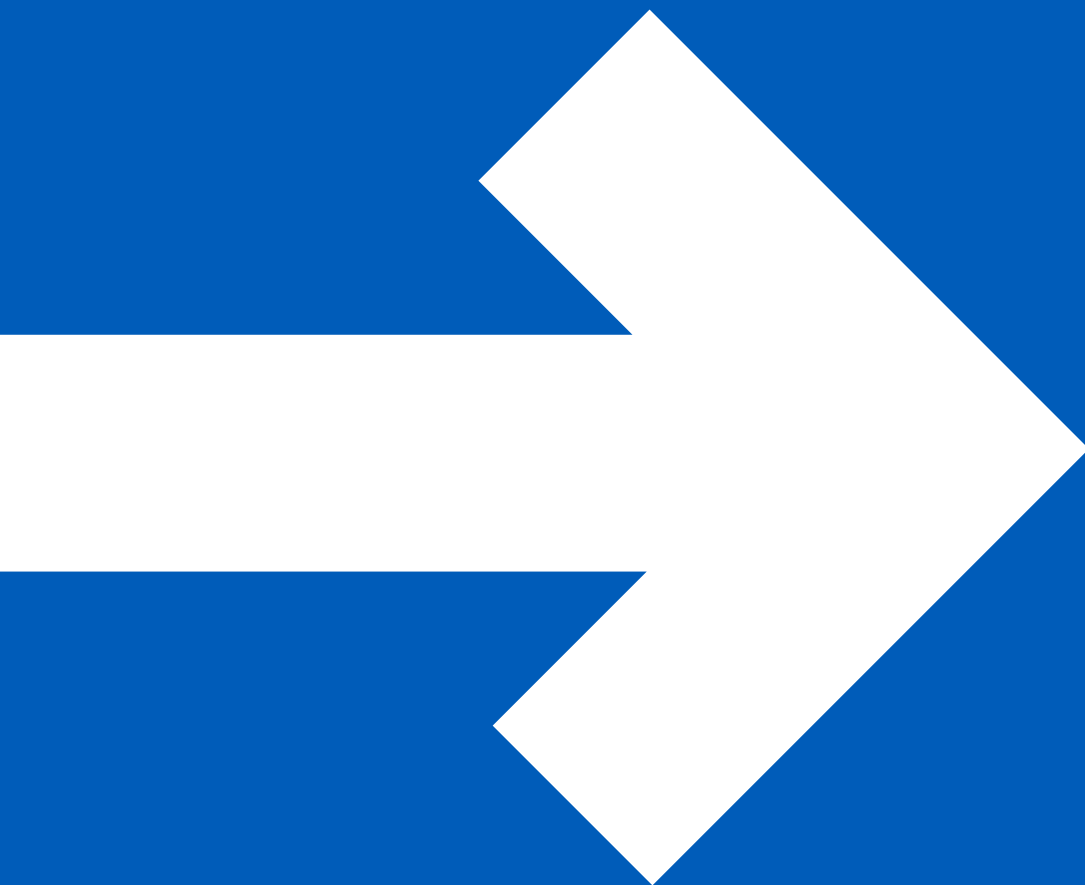


**STRATEGIC DIRECTION
FOR SEXUAL ASSAULT AND
ABUSE SERVICES**

Lifelong care for victims
and survivors: 2018 - 2023



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Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in, access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Acknowledgment of thanks

We would like to thank the many people who have contributed to and supported the development of this strategic direction.

Particular thanks go to victims and survivors of sexual assault and abuse who have worked with us throughout a lengthy engagement phase and who have continued to work with us throughout its development. Many have supported our understanding of the impact of sexual assault and abuse by sharing with us their own experiences.

Thanks also go to our partners across the care and justice system; as well as commissioners and providers of sexual assault and abuse services.

These different groups have all welcomed the opportunity to work together to develop a vision for a pathway of care over a lifetime rather than services that are accessed at a particular point in time.

The voice of victims and survivors has been central to the development of this strategic direction for sexual assault and abuse services. We will continue our work with victims and survivors, their families and carers, as well as with our partners across the care and justice system, commissioners and providers of services across England, as we implement the priorities that we have set out.

Foreword



Professor Jane Cummings
Chief Nursing Officer,
NHS England

Sexual assault and abuse are serious crimes which continue to have a significant impact on our society. Their devastating consequences can often be misunderstood and neglected.

This strategic direction represents a shared vision and a shared focus for improvement. NHS England's strategic partners and most importantly, victims and survivors of sexual assault and abuse, have welcomed the opportunity to work together to consult on the co-development of a health and well-being focussed strategy, which takes into account a lifelong pathway of care for survivors and seeks to drive the improvement of services now and in years to come. It outlines how services need to evolve to ensure that as much as possible can be done to safeguard individuals and to support them at times of crisis and in particular, at the point of disclosure.

Over the past year, many cases of sexual assault have been brought to the forefront of the nation's attention. When looking at the historical Rotherham case in particular, I was astounded by the number of times these young victims were let down by multiple agencies.

Cases like this highlight that every staff member, with a duty of care, has their own role to play in providing support and protection. No one can have the option of saying 'it's the responsibility of someone else'.

Even though certain cases of sexual assault and abuse receive national media coverage, we must remember that the vast number of victims remain hidden. Far too many victims remain fearful of coming forward or lack faith in organisations.

I know that many organisations have significantly improved the way that they offer support to victims of sexual assault and abuse, but we can and must do more. The points raised in this very valuable document offer a framework of guidance in doing just that.

The strategic direction is focussed on six core priorities for delivery across England, which are set out below. Each priority recognises the complexity of health and wellbeing for lifelong care for victims and survivors of sexual abuse; and the fact that individuals may already be known to a number of services, even prior to disclosing. The priorities also recognise that to be effective at meeting short, medium and long term needs over the lifetime of a survivor, care needs to be trauma informed and considered as part of an integrated and whole system pathway of care and not an isolated segment.

THE SIX CORE PRIORITIES

- **Strengthening the approach to prevention**
- **Promoting safeguarding and the safety, protection and welfare of victims and survivors**
- **Involving victims and survivors in the development and improvement of services**
- **Introducing consistent quality standards**
- **Driving collaboration and reducing fragmentation**
- **Ensuring an appropriately trained workforce**

Strategic direction for sexual assault and abuse services Lifelong care for victims and survivors: 2018 - 2023

As we play our part in encouraging and empowering survivors of sexual assault and abuse to come forward, the demand on services will be even greater. By working in partnership, we can offer an effective and efficient service that places victims and survivors of sexual assault and abuse at the very centre, which in turn will enable us to offer the support and care when and where it is needed the most.

Professor Jane Cummings

Chief Nursing Officer for England

1. What is sexual assault and abuse and who is affected?

In the context of this document, references to sexual assault and sexual abuse include rape and sexual violence. Examples of offences or circumstances where offences may occur include (but are not restricted to):

- sexual acts involving a child, sexual harassment, forced marriage, honour-based violence, female genital mutilation, human trafficking, sexual exploitation and ritual abuse; or
- any unwanted sexual activity with someone without their consent or agreement.

Sexual assault and abuse can happen to anyone; men, women and children; at any age, and may be a one-off event or happen repeatedly. In some cases it can involve the use of technology such as the internet or social media which may be associated with grooming, online sexual harassment and trolling.

Sexual assault and abuse are two of the most serious and damaging crimes in our society.

Some factors can make particular groups of people more at risk of sexual assault and abuse¹. These include people who:

- have a history of previous sexual abuse or who have experienced other forms of abuse
- have a disability
- are in care or who have a disrupted home life

- live without adequate supervision or who are isolated.

Risk factors can also vary depending on gender. Women are more likely to experience intimate partner violence if they have low education or exposure to their mother being abused by a partner².

Men are more likely than women to be subjected to institutional and clergy abuse as children, and prison-based sexual violence as adults³.

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. It is well known, however, that the damage and devastation caused are enormous, extremely varied and often lifelong. They present in different ways for different individuals from different genders and demographics; the commonality being serious trauma and often compound trauma. Feelings of profound fear, terror and anxiety have been described by victims and survivors, with safety and trust being significant factors in the recovery process.

It can take many years for an individual to disclose sexual assault or abuse, particularly those people who have been abused or assaulted as a child, or those with a disability.

¹ [NSPCC - who is affected by sexual abuse?](#);

[Measuring the scale and changing nature of child sexual abuse and child sexual exploitation - scoping report, Professor Liz Kelly and Kairika Karsna, July 2017;](#)

[The impacts of rape and sexual assault; World Health Organisation: World report on violence and health, chapter six.](#)

² [World Health Organisation: Violence against women, intimate partner and sexual violence against women, November 2017.](#)

³ Heilpern, 1998; Mariner, 2001; John Jay College of Criminal Justice, 2004; Parkinson, Oates et al., 2009.

Some facts and figures

- In the year ending September 2017, police recorded 138,045 sexual offences, the highest figure recorded since the introduction of the National Crime Recording Standard in 2002 and a 23 per cent increase on the previous year⁴.
- Around two per cent of adults aged 16-59 were victims of sexual assaults in the year ending March 2017⁵.
- It is estimated that up to 80 per cent of incidents are unreported and as few as 28 per cent of victims report their experience to the police⁶.
- More than a third of rape victims and half of female victims of other sexual offences, including assaults, grooming and sexual exploitation, are under the age of 16. Girls aged 10 to 14 are most likely to be the victims of reported rape⁷.
- Male sexual violation is one of the most under-reported crimes worldwide. The Ministry of Justice estimates that around one in ten victims of rape and attempted rape each year are male⁸.

⁴ [Crime in England and Wales: year ending September 2017, Office for National Statistics.](#)

⁵ [Crime in England and Wales: year ending March 2017, Office for National Statistics.](#)

⁶ [Howard League for Penal Reform: Coercive sex in prison: briefing paper by the commission on sex in prison, 2014.](#)

⁷ [Focus on violent crime and sexual offences, England and Wales: year ending March 2016, Office for National Statistics.](#)

⁸ [New support for male rape and sexual violence victims, 2014.](#)

2. The case for change

Heightened profile

Over recent years, the profile of sexual offences has been raised significantly due to the Children's Commissioner's Inquiry into Child Sexual Exploitation in the family environment, the Independent Inquiry into Child Sexual Abuse (IICSA)⁹, the independent inquiry into child sexual exploitation in Rotherham, the various cases involving well-known individuals and, most recently, the emerging cases associated with football. This is likely to have an impact on the uptake of mainstream services, and in particular, mental health services for non-recent victims and survivors of sexual assault and abuse.

The needs of victims and survivors

Victims and survivors tell us that, both before and after disclosure, they frequently find it difficult to navigate a confusing and disjointed array of services at the time when they need them most and at times when they are often in crisis. They also tell us that their experience can be compounded both by difficulties in knowing which services to access to get the help and support that they need, and by inconsistencies in the quality of care that they receive once they do access services. This heightens the risk of compound trauma that can occur as a result of repetitive, prolonged and sustained abuse and/or re-traumatisation, which is the reminder of a past experience resulting in re-experiencing the initial trauma. Heightening the risk further, disclosure and identification of sexual assault and abuse often takes place within a criminal justice setting rather than within a service dedicated to the care and support of victims and survivors.

This can often mean that, whilst support through the forensic and judicial process is available, there may be little emotional and physical support longer-term and over the individual's lifetime.

Victims and survivors of sexual assault and abuse have urged us to collaborate and to integrate services across the health, care and justice sectors to ensure that transition from one service into another is streamlined. They want us to focus on the quality and continuity of care and provide more joined up support for individuals, as well as for their families and carers. This includes improved information-sharing and communication between NHS and third sector organisations, as well as better referral pathways to ensure that victims and survivors are directed to the most appropriate service at the right time in their journey to recovery.

A complex system

The landscape for sexual assault and abuse services is wide and complex. It spans a number of different systems and government organisations, including health, care and justice, and requires them to work together. The commissioners of services are varied, and there is a wide range of providers, including some specialist and third sector organisations. This creates a significant challenge, and all the different bodies can find it difficult to work together effectively to meet the lifelong needs of victims and survivors. This can result in fragmentation in service delivery, frustration and poor outcomes for victims and survivors of sexual assault and abuse over their lifetime.

⁹ [Independent inquiry into child sexual abuse.](#)

3. Our vision

Our vision is to radically improve access to services for victims and survivors of sexual assault and abuse and support them to recover, heal and rebuild their lives. Our vision is in two parts:

- Firstly, for those who have experienced recent sexual assault and abuse and who are in the immediate aftermath, we must provide highly responsive, personal services delivered by trained doctors, nurses and support workers in settings that respect privacy and that are easy to access. These services should include specialist medical and forensic examinations, practical and emotional support and support through the judicial process.
- Secondly, for those who have experienced historic sexual assault and abuse, we must provide therapeutic care that recognises the devastating and lifelong consequences on mental health and physical and emotional wellbeing.

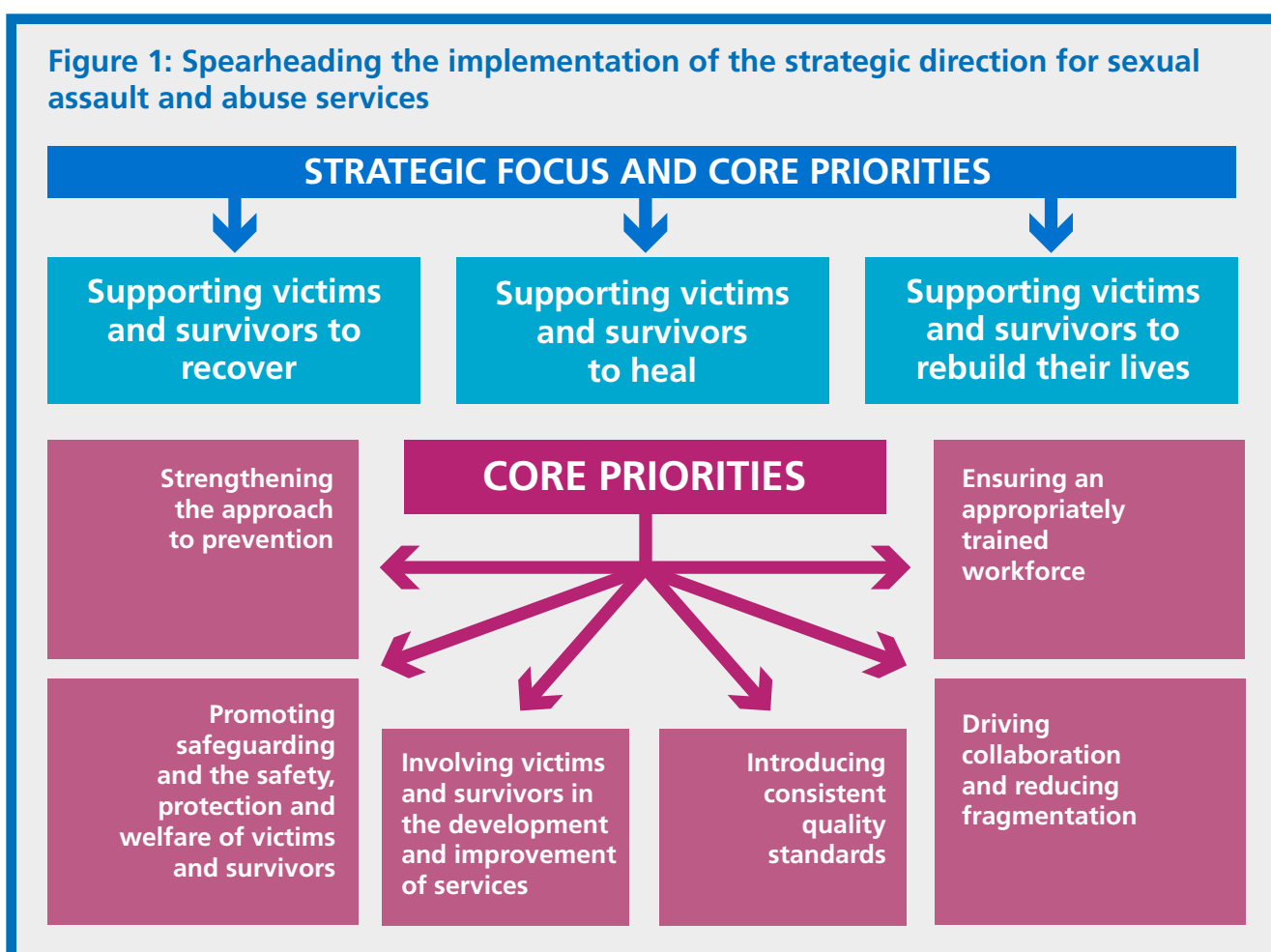
Underpinning both parts is the need for all commissioners and providers of services that support victims and survivors of sexual assault and abuse to work together to create a seamless approach that recognises individual needs and reduces fragmentation and gaps between services.

Our aim is therefore to improve health outcomes for victims and survivors of sexual assault and abuse.

4. Our strategy for improving sexual assault and abuse services

This chapter sets out our strategy for how we can improve the whole pathway of care for victims and survivors of sexual assault and abuse over a lifetime. Our strategy has been informed by an extensive period of engagement with strategic partners, providers, commissioners, victims, survivors from diverse communities and in some cases their families and carers, as well as the extensive evidence base.

Our approach is based around six core priorities, as figure 1 illustrates. This chapter explains what we will do to implement each of these priorities, and what difference implementation of each of the priorities will make.



Strengthening the approach to prevention

Preventing sexual assault and abuse from happening at all should be paramount and, for victims and survivors of previous incidents, reducing the risk of future re-victimisation is central to their recovery, healing, ability to rebuild their lives and ongoing safety.

Prevention is becoming more and more challenging^{10,11}. Many parents may find it difficult to talk to their children about the risks of sexual assault and abuse. Behaviours amongst adolescents are changing, particularly their understanding of healthy relationships, and it is also becoming more difficult to teach younger children how to keep themselves safe on social media and speak out if they need to.

The internet in particular has transformed the nature of sexual assault and abuse and the risks around sexual exploitation and harmful sexual behaviour. 'Sexting' and other age-inappropriate sexual behaviour, such as watching extreme pornography or making inappropriate remarks, have also become more commonplace.

The way children and young people use technology and social media can make them more vulnerable to sexual exploitation online. The charity Barnardo's suggests that children and young people at risk of online sexual abuse may be younger than those who experience other types of sexual exploitation and may not fit into standard definitions of 'vulnerable'.

There are other groups which may find it difficult to report sexual assault and abuse. This suggests that we need to focus our prevention efforts. This includes the lesbian, gay, bisexual and transgender (LGBT) communities, the black and minority ethnic communities, those with learning disabilities and sex workers, as well as all age groups within the prison population¹².

Every organisation involved in the delivery of sexual assault and abuse services has a responsibility to help stop these crimes from happening. Services across the whole pathway need to work in partnership to assess proactively, the risk amongst vulnerable groups, as well as previous victims and survivors, and to take action to minimise their exposure to harm.

¹⁰[NSPCC: Preventing Child Sexual Abuse: Towards a National Strategy for England, 2015, Jon Brown and Aliya Saied-Tessier.](#)

¹¹[Over the Internet, Under the Radar: Prevention of Online Child Sexual Abuse and Exploitation in Scotland, February 2017, Centre for Youth & Criminal Justice.](#)

¹²[Supporting LGBTI survivors of sexual violence, Rape Crisis Scotland, 2014; Between the Lines: Service Responses to Black and Minority Ethnic \(BME\) Women and Girls Experiencing Sexual Violence, 2015, Dr. Ravi K. Thiara, Sumanta Roy and Dr. Patricia Ng; 'Many women of colour don't go to the police after sexual assault for a reason' news article; Behind closed doors. Preventing sexual abuse against adults with a learning disability, September 2001 page 6; Female sex workers, 2018; Male sex workers, 2017; Howard League for Penal Reform: Coercive sex in prison: briefing paper by the commission on sex in prison, 2014.](#)

To achieve this, we will:

- implement recently-published guidance from the National Institute for Health and Care Excellence on what is known as harmful sexual behaviour. The guidance focusses on children and young people who carry out harmful sexual activities, directed either towards themselves or others¹³. In order to make sure that effective implementation happens, we will:
 - ensure that the guidance reaches the relevant NHS England commissioned services
 - undertake discussions with the national Sexual Assault Referral Centre (SARC) Clinical Forum around the appropriateness of developing specific care pathways for children and young people who display harmful sexual behaviours
 - work with partner organisations to input health expertise into the development of their interventions
 - work with NHS England's SARC Clinical Forum and Lived Experience Group to support an improvement in access to services by developing and sharing information which raises awareness of service availability
 - collaborate with the Home Office, as they implement their Disrespect Nobody campaign and refresh their Violence Against Women and Girls (VAWG) strategy to make sure that they are reflected within NHS commissioning plans
- work with the police to:
 - develop a prevention plan aimed at vulnerable groups. This will focus on awareness raising and education, and will include the development of a National Intelligence Model profile by the police for the sexual assault and abuse of children, young people and adults
 - increase awareness of the services provided by SARCs, particularly through the LGBT communities, BME communities and vulnerable women's centres
 - develop easy-read information on the role of a SARC for people with learning disabilities.

¹³[Harmful sexual behaviour among children and young people guidance from NICE \(National Institute for Health and Care Excellence\), September 2016.](#)

CASE STUDY

During a session being delivered by a third sector organisation, to a group of year 10 students on healthy relationships and consent, a 14 year old girl became distressed and upset. She spoke privately to one of the staff and went on to disclose that she was being sexually assaulted and raped by an older cousin and had been since the age of 11.

Guilt and shame had prevented her from telling anyone before. She was worried that it was her fault because she had never said no or told him to stop and it had happened on more than one occasion. She was also worried about getting into trouble for under age sex.

She was given immediate support; the school's designated safeguarding lead was engaged and given support to tell her parents. She was signposted to further help and support and was able to talk about the risks around future safeguarding and prevention.

She later self-referred for counselling and Independent Sexual Violence Advisor (ISVA) support and was given help in terms of understanding her choices regarding the judicial process.

She remained in counselling for a year, which helped her to process and overcome the trauma she had experienced.

She continues to attend school and understands the importance of healthy relationships.

CASE STUDY

A 53 year old male was sexually abused as a teenager. His experience was complex and traumatic and occurred at a developmentally sensitive stage in his own life.

He has a long history of depression, anxiety and anger issues and an inability to express emotion, as well as experiencing chronic feelings of shame, guilt and self-blame. He also has a conviction for a non-contact, online sexual offence.

For years, he was unable to disclose or speak about his experience as a victim and certainly his involvement as a perpetrator.

As part of his need to recover and 'change', he accessed a psychotherapy-based prevention programme and completed 23 sessions.

For survivors of sexual assault and abuse, psychotherapy highlights and educates individuals and communities on the destructive impacts of sexual assault and abuse; and for survivors who have sexually offended, the delivery of trauma-informed psychotherapy addresses the offender's trauma with the aim of reducing offending.

Promoting safeguarding and the safety, protection and welfare of victims and survivors

The responsibility to prevent sexual assault and abuse also includes a responsibility to safeguard those who we know to be particularly vulnerable and those who are placed in the care of others. Supporting this responsibility is the Health and Social Care Act 2012, Working Together to Safeguard Children (2015) which is currently under review with an updated version expected in 2018, the Children Act (2004) and supporting vulnerable adults, the Care Act (2014).

Safeguarding is by far the most effective way to protect children, young people and vulnerable adults against any form of harm, abuse and neglect, and safeguarding the individuals that engage with them should be a priority for all providers of services.

Across all organisations that have a caring responsibility for vulnerable adults, children and young people, measures should be in place to ensure that any suspicion of sexual assault or abuse is investigated and acted upon. If safeguarding measures are not assured, and vulnerable adults, children and young people are not safeguarded, the risks of sexual assault and abuse become higher. For victims and survivors of sexual assault and abuse, in particular, the risk of re-victimisation and re-traumatisation become significantly greater, to the detriment of their health and wellbeing. This is particularly relevant for individuals in their teenage years. Early identification of any form of sexual assault and abuse is therefore fundamental to any health outcome.

Particular consideration should be given to safeguarding those whose circumstances make it difficult to report their sexual assault or abuse and who may feel reluctant to make a disclosure. For instance, those whose immigration status is uncertain, who have minor criminal offences, those who are misusing substances, those with a specific language barrier and in particular, those whose families are carers or have been involved in any assault or abuse that has taken or is taking place.

Making a commitment to safeguard individuals also means that statutory and specialist third sector organisations must work together at both strategic and operational levels. Joined-up, collaborative working (see page 20) is paramount.

To achieve this, we will:

- develop and use commissioning frameworks that explicitly describe what safeguarding means for victims and survivors of sexual assault and abuse, define responsibilities and clarify what is expected of providers of services
- improve information sharing by supporting the Child Protection Information Sharing (CPIS) programme which aims to ensure that 80% of unscheduled care settings are signed up to the CPIS protocol by 2019. This will allow service providers to understand if a child or young person is already known to services.

CASE STUDY

A mother of two teenagers has been supporting the eldest following rape by a stranger five years ago when she was 13.

The trauma which followed led to her daughter's withdrawal from school, attempted suicide and several episodes of care in a mental health unit.

Initially, the mother felt that she received little support to help her communicate with her daughter. As a result, she was interacting with her daughter without being guided as to what might help, hinder or even cause further damage to her daughter's already fragile state.

The mother attended counselling which began to have a positive impact on how she was able to behave and communicate with her daughter. Over time, she was able to start giving her daughter more freedom and was able to begin to 'let go'.

Her daughter has now started to re-build her life with appropriate support from her mother and is able to go out and socialise independently.

Involving victims and survivors in the development and improvement of services

Victims, survivors and advocacy organisations are the most important voices in service re-design and development in terms of their ability and power to help others to recognise and to understand the scale, complexity and impact of sexual violation.

Involving survivors and advocacy organisations in the improvement and development of services, offers an opportunity for them to be heard without judgement or stigmatisation. It is vital that we use their expertise to influence service improvement through direct experience.

When involving victims and survivors in the development and improvement of services, it is important to consider a range of options to involve people. For example, engaging with men may need a different approach to that used to engage with women and likewise for children and younger people.

To achieve this, we will:

- develop, publish and circulate a set of principles to govern the involvement of survivors and survivors' advocates in the commissioning and delivery of sexual assault and abuse services. These principles will build upon NHS England's 'What Works' publication and will be developed jointly with the wide range of stakeholders who have helped us to develop this strategy. They will be circulated to all organisations that commission or provide services which support victims and survivors of sexual assault and abuse.

- establish a national victims' and survivors' voices group, managed by NHS England. This group will help to ensure that ongoing service developments are informed by lived experience and will help to hold services to account for the actions described in this strategy.

CASE STUDY

A mother of a 15 year old girl with learning disabilities who had been sexually abused was referred by her GP to the local Improving Access to Psychological Therapies (IAPT) programme.

In the assessment session, the mother disclosed that she herself had been subject to sexual abuse at the age of 14. This disclosure triggered contact from the police which was unexpected, as she had not been involved in a decision to contact them. It also triggered an unexpected concern over the safety of her daughter.

The mother immediately lost trust in health professionals and has not accessed the IAPT service since. She feels that she should have been involved in any decision to involve the police and been included in any discussion regarding any perceived or potential safeguarding risks.

Introducing consistent quality standards

Victims and survivors of sexual assault and abuse describe significant variation in the quality of service they experience when trying to access support. When they do receive support, some feel that their needs are poorly recognised and, for some victims and survivors, it has taken multiple attempts over many years to get the help, care and support that they need. This is made considerably harder at times when individuals are experiencing significant trauma and are in severe crisis.

The delivery of good quality, consistent care to victims and survivors of sexual assault and abuse is paramount to their ability to recover, heal and rebuild their lives. Regardless of the part of the country in which they are accessing services and regardless of their gender, ethnicity, sexual orientation, age and relationship with the criminal justice system, the standard and quality of care should be the same.

Any standards should particularly support those people with disabilities, as they will often face additional difficulties in attempting to access support. They may already be socially isolated because of their disability and may find it difficult to disclose as they may have no opportunity to seek help without their abuser being present. Victims and survivors with a specific language barrier and, in particular, those who rely on sign language, may also face additional difficulties in accessing support.

Consistent quality standards are also important in paediatric services to ensure that we can meet the complex needs of child victims. The paediatric model requires mechanisms that ensure timely and easy access and structured, seamless referral into clinical commissioning group (CCG) commissioned child and adolescent mental health services and other specialist support. For example paediatric genito-urinary medicine (GUM) services for children under the age of 13 and services provided by the third sector to ensure access to appropriate assessment, treatment and ongoing specialist care. Structured and seamless transition from paediatric services into adult services should be included as part of the standards.

A set of standards will not only help us to drive up quality, but also measure our success and understand whether we are doing the right thing, at the right time, to achieve the best possible results for victims and survivors.

To achieve this, we will:

- work with organisations across the health, care and justice sectors, as well as victims and survivors, to develop a set of quality standards that:
 - supports delivery of the best possible outcomes for individuals accessing services and care
 - sets a clear expectation that care is compassionate, sensitive and delivered in a non-judgemental manner and is centred around the needs of the victim or survivor
 - is underpinned by a strong governance and accountability framework that is clear about the role of each organisation within the system and what is expected of them

- provides a framework against which to measure and evaluate the quality of care, identify gaps, support future goal setting and a cycle of continuous improvement
- informs future policy and commissioning decisions
- supports the criminal justice process
- reflects interdependencies across the health, social care and criminal justice systems
- revise existing service specifications to include specific quality standards, reduce variation and highlight interdependencies with other services such as:
 - adult and paediatric services
 - therapeutic support
 - educational, training and clinical requirements
 - leadership and governance arrangements.
- work with the Care Quality Commission (CQC) to ensure that their programme of SARC inspections, due to commence in 2018, is based on a strong, person-focused inspection regime that examines the wider pathways of care for sexual assault and abuse
- work with other commissioners to ensure that interdependencies throughout pathways of care are reflected in the associated service specifications, in particular around access to:
 - paediatrics, including GUM services for children under the age of 13
 - specialist mental health services which children, young people and adults can access.

CASE STUDY

Following a successful pilot, a quality assurance programme took place across London's three SARCs and later across the four SARCs in Kent, Surrey and Sussex.

Associated quality standards were developed based on the national service specification (commonly known as Specification 30) and reframed to reflect the five CQC domains (safe, caring, effective, responsive and well-led).

By introducing quality standards, it has supported an enhanced service for adults and children and young people's services:

- The Havens SARCs are delivering the first UK service, which is based on child house principles, incorporating early intervention, psychological therapy for children and young people, and sexual assault victims, as well as police involvement. Achieving Best Evidence interviews are being conducted by clinical psychologists in a safe and therapeutic environment.
- Kent, Surrey and Sussex have brought together the Crown Prosecution Service, the three police services and the four SARCs to develop a regional Forensic Improvement Plan.

The quality assurance process has also identified best practice associated with care for children with a learning disability.

For example: In the South (Brighton and Sussex), staff worked closely with the family and support staff of a child before she came in for a medical examination following an assault. The family were sent photos of the room she would be examined in and information about what to expect to help prepare the child. The service always requests a health passport in advance and has a robust relationship with the appropriate third sector agency to ensure additional support is in place if required, particularly where the child's language and communication skills may be limited.

Driving collaboration and reducing fragmentation

Victims and survivors of sexual assault and abuse tell us that their experience of moving between the health, social care and criminal justice systems is fragmented and that services can be difficult to navigate. This strategic direction sets out how a joined-up approach to the commissioning and provision of services is vital if we are to provide people with the right support at the right time. Victims and survivors, along with their information, should flow seamlessly between the different services, including those provided by specialist third sector organisations, without complication and over their lifetime. Without this collaboration, we run the risk that limited access to support services and therapeutic provision; high thresholds and long waiting lists will harm the recovery of victims and survivors.

Delivery of joined-up care needs to recognise the highly varied needs of individuals. 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. Unlike some other services, the commissioning and provision of services supporting those who have been sexually assaulted or abused cannot be channelled through a linear pathway of care. Prior to disclosure, a number of different service providers may have been involved in an individual's care and support. For example, as a direct result of negative behaviours, such as drug or alcohol dependency, self-harm, sexual risk taking and some criminal behaviours, victims and survivors may already be known to specialist and community mental health teams or crisis support services, as well as addiction, community sexual health or educational support teams, social services or the criminal justice system.

Collaboration and a reduction in fragmentation should underpin the delivery of all priorities set out within this strategic direction and in particular, should form part of the quality standards for sexual assault and abuse.

To achieve this, we will:

- ask all organisations that commission or deliver services to sign up to a new governance framework that explicitly outlines the outcomes that they are expected to achieve and how they will report those outcomes. This will be done through the Sexual Assault and Abuse Services (SAAS) Partnership Board, which includes representation from national, regional and local commissioners, including Accountable Care Organisations, Sustainability and Transformation Partnerships, CCGs, local authorities, Police and Crime Commissioners and voluntary sector organisations
- ensure the commissioning of services is trauma informed. This will be done by ensuring that service specifications and tenders recognise and encourage the links between the trauma victims and survivors of sexual assault and abuse experience and mental health, as well as the benefits of the principles of integrated child house type models
- improve information sharing between regional teams around procurement opportunities in order to ensure the best response from the market.

CASE STUDY

A 43 year old male was sexually abused as a teenager and remained silent until the age of 40.

He has a long history of drug and alcohol misuse, deliberate self-harm and three significant suicide attempts. He is well known to health care service providers and has once been sectioned under the Mental Health Act.

He had been offered help and support before, but first engaged in specialised sexual violence support following a discussion with his GP. This led to a referral to access 'drop in' services and later therapeutic services.

Whilst engaging in therapeutic services, his psychiatrist changed, as did the advice that he was given regarding continuation with therapeutic services. This change agitated his issues with trust and abandonment and may have contributed to a fourth suicide attempt.

Knowing of his engagement with the service providing specialist sexual violence support and the impact it was having, his GP requested their assistance in re-establishing his care pathway by instigating a multi-disciplinary care planning meeting.

Multi-agency planning and support contributed to safeguarding the individual, ensuring his wider needs were met and that he continued to commit to his pathway of care and engage with service providers.

Ensuring an appropriately trained workforce

The trauma that victims and survivors of sexual assault and abuse experience manifests in many ways: disrupting health and development, adversely affecting relationships and contributing to significant mental health issues. A trauma-informed approach to care links trauma and mental health by recognising its effects and human response. It emphasises the need for physical, psychological and emotional safety and helps survivors to recover, heal and rebuild a sense of control and empowerment.

In order to help and support victims and survivors of sexual assault and abuse who may be experiencing complex trauma and re-traumatisation and achieve the best outcome, it is important that those with whom they come into contact at any given point in their journey to recovery are appropriately trained and are aware of the effects and manifestations of sexual assault and abuse.

At the point of disclosure and identification of sexual assault and abuse, for example, victims and survivors will often be in severe crisis. It is important that first responders understand how to act and can provide a consistent level of service to the individual making the disclosure¹⁴. Initial disclosure may happen within a criminal justice setting where there may be support and expertise available. However, disclosure and consequent care will unavoidably take place in mainstream services where, we are told, the same level of awareness, knowledge and expertise may not be present.

Examples of mainstream services could include, but are not exclusive to, maternity, gynaecology, infertility, community sexual health, teenage pregnancy and gender reassignment services.

Wherever disclosure takes place, many victims and survivors of sexual assault and abuse describe feeling let down and disappointed when seeking the help they need. They describe delays in being able to access initial help and support and suggest that, when they do, many professionals across the health and social care system have an inadequate understanding of and empathy for sexual assault and abuse and often fail to link behaviour and symptoms to the underlying trauma. In some cases, we are told that service providers can fail to recognise men and boys as victims of sexual assault and abuse, rape and sexual exploitation, which further increases their vulnerability.

Victims and survivors also tell us that, once a disclosure has been made, there can be a lack of knowledge amongst service providers about where to seek the specialist support required, and a lack of support for onward referral. Given the likelihood that victims and survivors could still be in or facing crisis, there is a risk of dual diagnosis such as depression and anxiety disorders and mis-diagnosis of dissociative disorders, such as Post Traumatic Stress Disorder (PTSD) and Attention Deficit Disorder (ADHD).

¹⁴ [Report of the independent review into the investigation and prosecution of rape in London, Rt Hon Dame Elish Angiolini DBE QC \(April 2015\).](#)

When supporting and caring for victims and survivors of sexual assault and abuse, professionals need to ensure that they display an appropriate understanding of and empathy for its impact on both men and women. When this fails to happen, it can exacerbate the burden of victim and survivor shame and unnecessarily prolong the length of time that it takes to access the right support. This can have a significant impact on diagnosis, recovery and trust.

To achieve best outcomes for victims and survivors, it is essential that awareness of the impact of sexual assault and abuse is raised across the whole workforce in order to minimise the risk of re-traumatisation and any unanticipated trauma and ensure that care and support are delivered at each stage of an individual's journey to recovery.

We hope that, by improving awareness and training across the workforce, victims and survivors will be better able to access specialised services, safeguarding will be enhanced, the quality of care received improved and ultimately patient experience and outcomes heightened.

To achieve this, we will:

- include workforce requirements in the quality standards (page 18). This should cover training needs and guidance on optimal skill mix
- set out workforce requirements within the quality standards, identify training needs against quality standards and work with commissioners to ensure that they have plans for meeting any gaps
- require all providers to develop workforce plans, which include a process for developing skills and competencies to the national standards
- ask the newly established SARC Clinical Forum to adopt 'workforce' as one of its key work streams
- work with therapeutic providers, including the specialist voluntary sector, to develop guidance on delivering trauma-informed services aligned to the Crown Prosecution Service provision of pre-trial therapy guidance.

CASE STUDY

A 40 year old female was abused between the age of five and 16.

In her late teens she developed obsessive-compulsive disorder (OCD) which took over her life, and also suffered depression and anxiety.

She accessed her GP and made a disclosure about her abuse. Whilst her GP was sympathetic, she was told that therapy often left people in pieces; so she decided not to bother.

A few years later, she found the courage to call a women's centre, which dealt with physical and sexual abuse. The person that she spoke to was dismissive and so she decided not to seek help again.

Later still, she saw another GP who referred her for specialist counselling and she has since accessed a ten week group course for adult survivors of sexual abuse.

She states that, based on her experience, health professionals and society need more awareness of sexual abuse and its impact, both to prevent it happening and to encourage survivors of all ages to cast aside misplaced shame and come forward to receive help.

CASE STUDY

A 20 year old male with a hearing impairment experienced sexual abuse as a child. As an adult he suffered flashbacks, night terrors and depression. He disclosed to his GP as an adult.

He was referred to a counsellor who engaged the services of a British Sign Language (BSL) interpreter. However, as neither the counsellor nor the interpreter had specialist understanding of sexual assault and abuse and as BSL is a visual language, the experience became too traumatic.

A partnership has since formed between a supporting third sector organisation, BSL and a specialist in the health of the deaf community. The ambition of the partnership is to create a greater understanding of the needs of hearing impaired survivors of sexual assault and abuse and increase communication models for BSL signers and interpreters to ensure that any risk of re-traumatisation through sign is limited.

5. Delivering the strategic direction for sexual assault and abuse services

Across some parts of the country, there are already services for victims and survivors of sexual assault and abuse that are taking positive steps to work collaboratively and improve quality. Driven by the ambition set out in this strategic direction, we need to ensure that good practice is shared and a cycle of continuous improvement is embedded, so that service delivery is consistent and variation reduced throughout England.

If we are successful, we believe this will deliver:

- better health outcomes for victims and survivors
- greater value for money; and
- a reduction in:
 - emergency department attendances
 - GP visits
 - recidivism of survivors as offenders (both non-sexual and sexual offending).

Government departments and national and local organisations with responsibility for commissioning these services, need to ensure that existing and newly commissioned services are developed and delivered in line with this strategic direction and with the new quality standards for sexual assault and abuse services. A significant number of these services are delivered by the third sector and the same high standards must apply.

This is a five year strategy and its delivery will be supported by a detailed delivery plan which will be published later on this year.

We will monitor progress through established governance mechanisms, primarily NHS England's Health and Justice Oversight Group and the Sexual Assault and Abuse Services Partnership Board. We will use the new, national victims' and survivors' voices group (page 17) to hold these groups to account for delivery. Progress will be ascertained by self-assessment against the quality standards with an accompanying verification process alongside findings from the CQC's inspection process, which is due to commence during 2018. We will publish further details of this process when we publish the quality standards.

Throughout its duration and by taking the action proposed, we expect to see a significant improvement in a number of areas across the health, care and criminal justice systems.

In particular and through action taken which is supported by the information gathered through the proposed gap analysis, self-assessment against quality standards and the result of CQC inspections, we expect to see service delivery and victim and survivor experience and outcomes improve.

Annexe 1: Commissioning responsibilities

Commissioning responsibility	Service
NHS England	<ul style="list-style-type: none"> • 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 groups	<ul style="list-style-type: none"> • Mental health and Improving Access to Psychological Therapies (IAPT); services for depression and Post-Traumatic Stress Disorder (PTSD) that understand the specific needs of 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 Crime Commissioners	<ul style="list-style-type: none"> • Specific commissioning responsibilities for victims, including victims of sexual assault and abuse • Specialist voluntary sector services • Police 101 • In some forces, the police lead on the procurement of SARC services
Local authorities	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • National services for victims of child sexual abuse

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact **0300 311 2233** or e-mail england.contactus@nhs.net stating that this document is owned by the Health & Justice, Armed Forces and Sexual Assault Referral Centre (SARC) Team, Specialised Commissioning Directorate.

Legal guidance for NHS commissioners on equality and health inequalities duties is available at: <https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/>