Ministry of Justice

Formal support needs of adult victim-survivors of sexual violence: A literature review

Katie Silk

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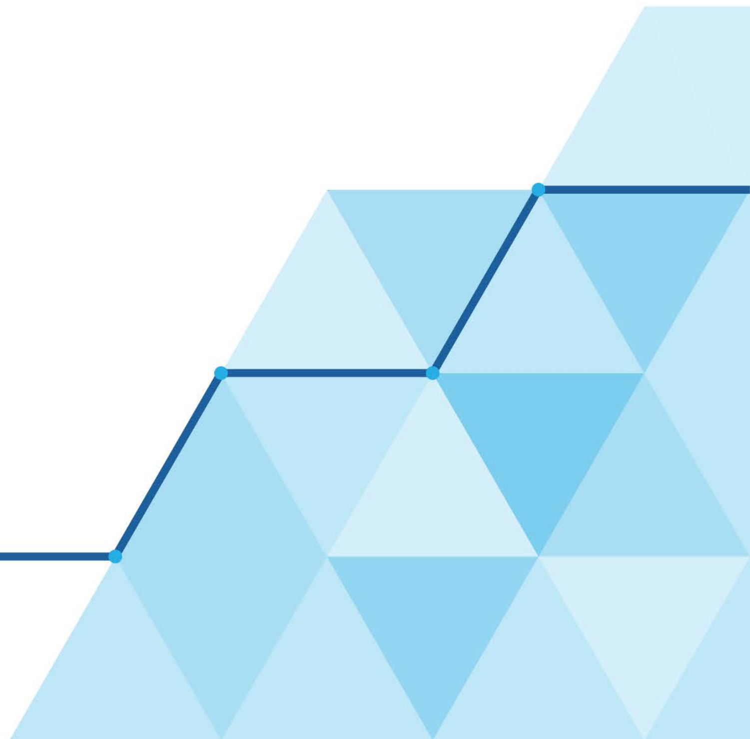

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Glossary of Terms and Definitions

BME	Black and Minority Ethnic
By and for services	Specialist services that are led, designed and delivered by and for the users and communities they aim to service, for example there are by and for services for disabled victim-survivors
CJS	Criminal Justice System
Covid-19	Coronavirus disease
CSEW	Crime Survey for England and Wales
DASH/SV	Domestic abuse, stalking and harassment and sexual violence
D/SV	Domestic abuse and sexual violence
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire and Rescue Services
Intersectionality	Intersectionality describes how social divisions can overlap, creating multiple levels of social injustice
ISVA	Independent Sexual Violence Advisor – an advisor that works with victims of rape and sexual assault to provide specialist tailored support
LGBT	Lesbian, gay, bisexual and transgender
LGBT+	Lesbian, gay, bisexual, transgender plus[1]
MOJ	Ministry of Justice
ONS	Office for National Statistics

[1] Please note, LGBT+ is the standard abbreviation, therefore where LGBT has been used, this mirrors the language used in the source literature. Where there is reference to multiple literature sources that use various acronyms, LGBT+ is used

RASASF	Rape and Sexual Abuse Support Fund, which provides funding to rape and sexual abuse support providers, to deliver vital support to victim-survivors. This is a fund provided by the Ministry of Justice.
Sexual violence	Any sexual act which is perpetrated without freely given consent, including acts which are offences under the Sexual Offences Act 2003
SARC	Sexual Assault Referral Centre – specialist forensic and medical services for victims of rape and sexual assault. They are normally provided by the NHS.
Specialist sexual violence support services	Support services whose primary purpose is to address, prevent and tackle sexual violence and support survivors
Trans	An umbrella term to refer to a diverse range of people who find their gender identity does not fully correspond with the sex assigned to them at birth
Trauma-informed care	Understanding the prevalence and nature of trauma arising from interpersonal violence and its impacts on other areas of life and functioning. Practices should ensure the physical and emotional safety of survivors and recognise and be responsive to the lived social and cultural contexts which shape victims needs and healing pathways

1. Introduction

Rape and sexual violence have devastating impacts on victim-survivors' lives. Direct negative impacts include long-term physical, psychological and social impacts of being a victim-survivor (McNaughton, Harvey & Paskell, 2014). These include anxiety, depression and post-traumatic stress disorder. In addition, there are secondary impacts including difficulties forming and maintaining relationships and reduction in ability to work or study. The impacts of sexual violence can also extend out further to non-perpetrator partners, children, family and friends of the victim-survivor. These individuals can experience secondary effects of trauma, as knowledge of a traumatising event experienced by a significant other is traumatic in itself (Boyd, 2011).

The End-to-End Rape Review report revealed that victim-survivors are not always getting the support that they need and many feel let down by the criminal justice system (CJS) (George & Ferguson, 2021). For example, the report highlighted that one stand-out reason for victim disengagement from the criminal justice system is the lack of available support to help victims remain engaged in the criminal justice system. The Ministry of Justice (MoJ) therefore made a commitment in the End-to-End Rape Review Action Plan, to conduct "targeted research with rape victims to better understand their experiences and what they want from support services so that future provision meets need" (HM Government, 2021, p.12).

MoJ will be recommissioning the Rape and Sexual Abuse Support Fund (RASASF). The RASASF provides funding to rape and sexual abuse support providers to deliver vital support to victim-survivors. To help ensure the recommissioning of the RASASF meets the needs of victim-survivors, there is demonstrated need to better understand the barriers victim-survivors face in accessing support, how these barriers can be addressed, what victim-survivors formal support needs are and the effectiveness of such support. A three-strand research programme was therefore developed to ensure the recommissioning process was evidence-based. The first strand of this research was a literature review exploring the existing evidence base in relation to this topic. The findings from this literature review subsequently fed into the recommissioning process and highlighted key

evidence gaps intended to be addressed through the second strand of the research which was a survey with rape and sexual violence victim-survivors. The third strand of the research consisted of qualitative interviews and focus groups with disabled rape and sexual violence victim-survivors to better understand their support needs given the lack of existing evidence relating to disabled victim-survivors.

This report relates to the first strand of the research programme: a literature review of the existing evidence. It is intended to be read alongside the research reports from the two other strands of the research programme: the survey (Silk, Larsen & Finnemore, 2023) and the qualitative research with disabled victim-survivors (Hollomotz, Burch & Bashall, 2023), which have been published alongside this report.

Rape and sexual violence are crimes that disproportionately impact women. The Crime Survey for England and Wales (CSEW) estimated that for the year ending March 2020 there were 773,000 adults aged 16 to 74 years who were victims of sexual assault (including attempts) in the last year, with almost four times as many female victims (618,000) as male victims (155,000) (ONS, 2021).Whilst the review explores research in relation to male and female victim-survivors, many studies either solely focused on the support needs of females or samples that were predominately made up of female victim-survivors. Unless otherwise stated, findings in this review therefore predominately relate to female victim-survivors.

The literature review set out to answer the following research questions in relation to adult victim-survivors of rape and serious sexual violence.

1. What barriers do victim-survivors face when accessing support? How, if at all, does this vary based on victim-survivor characteristics?
2. What support do victim-survivors want in terms of content (type of support) and process (how support is delivered)? How, if at all, does this vary based on victim-survivor characteristics?
3. What works and does not work in supporting victims in terms of:
    - Effective engagement with support services;
    - Effective engagement with different stages in the criminal justice system;
    - Supporting victims' to better cope and recover from their crime.

The review also sought to identify the existing evidence gaps in relation to the above research questions. Exploring the support needs of child victim-survivors of sexual violence, victim-survivors' family and friends and support workers fell out of scope of this review.

Report structure

Section 2 of this report sets out the methodology adopted in the literature review, before summarising the key findings in relation to each research question in Section 3. Whilst examining literature, distinct themes emerged in relation to the barriers victim-survivors face when accessing support, which links closely to their support needs. The themes are grouped within individual level factors (Section 4), social and cultural factors (Section 5) and structural factors (Section 6). Within sections 4 to 6, each sub-section outlines the evidence in relation to the barrier's victim-survivors face in relation to the theme, followed by what support victim-survivors want and, where available, evidence on the effectiveness of this support. Section 7 concludes the review, highlighting key evidence gaps and next steps for research. A more detailed summary of each reviewed paper, including detail on the methodology of the research, can be found within Appendix A.

Note on language

Throughout the report the term 'victim-survivor' is used for consistency; it refers to any complainant or victim of rape or sexual violence, including both those who have and have not reported to the police and both those who have and have not sought formal support.

Where possible, the evidence is in relation to sexual violence that was experienced as an adult. However, some literature covered both historic and adult sexual abuse and in these instances it was not possible to distinguish between findings for each. Whilst recognising that the needs of rape victim-survivors may be different from the needs of victim-survivors of other sexual violence or that needs may vary due to the context of the sexual violence (e.g. domestic abuse), it was not possible to determine whether findings were distinct for different types of sexual violence and different contexts. Therefore, within this report the term 'sexual violence' is used for consistency to encompass any sexual act which is perpetrated without freely given consent, including rape.

In this report, where a specific paper is discussed, the terminology from that paper is used. However, when summarising findings from multiple studies and within the recommendations, government guidance on appropriate terminology is followed. For example, some studies refer to 'black and ethnic minority' (BME) respondents, so the same terminology is used when describing findings from those studies. However, it is standard government practice to use the term 'ethnic minorities', so where recommendations are provided, this terminology is used instead. It is important to note however that this can mask differences between minoritised groups that fall under this term.

2. Methodology

The literature review explored the current evidence base of both quantitative and qualitative empirical research conducted directly with adult sexual violence victim-survivors and/or practitioners (i.e. support providers) who work closely with adult victim-survivors. The literature search was conducted in November 2021 with further checks in October 2022.

The literature review included the following high quality,[2] relevant research:

- On barriers adult victim-survivors face in accessing support services for both those who accessed support and those who did not;
- Relating to sexual violence adult victim-survivors support needs;
- On the effectiveness of support for both those going through the criminal justice process and those who did not enter the criminal justice system;
- Written in English language from 2011 onwards;
- From both academic and non-academic sources;
- International research which was published in English language.

The literature review did not include:

- Research published prior to 2011;
- Research published only in non-electronic formats;
- Research written in a language other than English;
- Low quality research;[3]
- Research that was not deemed relevant to the research question;
- Theoretical research from the perspective of authors/academics only as opposed to the views of adult victim-survivors or the practitioners working to support them.

[2] High quality was ensured by only including publications which specified sufficient details of the methods used to enable the author of this literature review to evaluate and confirm the reliability and rigour of the methodologies used. For example, publications were excluded where sample sizes were not stated.

[3] Low quality research is either uninterpretable (for example, due to limited explanations on methodology, sample and/or findings), likely to be biased or inaccurate.

Literature searches were conducted by the MoJ library using EBSCO and ProQuest using keywords relating to the research questions (see Appendix B). Appendix C outlines the products the EBSCO and ProQuest resources contain. Searches made use of keywords in title search, combined with a subject and abstract search. Supplementary searches using Core and ResearchGate search engines were conducted using keywords.

The literature search identified a total of 936 papers. All abstracts were reviewed for relevance and quality. A total of 54 published research documents were deemed to be of both high enough quality and relevance to include in this literature review. All 54 papers were reviewed by two researchers independently for accuracy and relevance.

Table 1: Number and percentage of qualitative, quantitative and mixed methods papers included in the review

	Number of identified papers	Percentage of identified papers
Qualitative	29	54%
Quantitative (including randomised control trials)	8	15%
Mixed methods (including surveys where there were both open and closed questions)	15	28%
Literature review	2	4%

Note: Totals do not equal 100 per cent due to rounding of percentages.

Table 2: Number and percentage of papers identified with findings which provide evidence in relation to each research question included in the review

	Number of identified papers	Percentage of identified papers
Barriers adult victim-survivors face in accessing formal support services	30	56%
What adult victim-survivors want from formal support services	33	61%
Effectiveness of support	14	26%

Note: The percentages do not total 100 per cent as some papers identified addressed more than one research question.

Of the 54 papers included in this review, 23 were from England and Wales, 16 from the USA, 3 from Canada, 2 from Australia, 2 from the Netherlands and the rest from Scotland, France, Italy, South Africa, Hong Kong and Northern Ireland. Detail of each individual paper included within the review can be found in Appendix A.

When reviewing each relevant article, a summary of the research and the main findings in relation to each research question were recorded in a summary table. An inductive approach was taken to thematic analysis whereby themes were identified based on relevance to the research question and transferability to the context in England and Wales. Key themes were recorded in an additional column of the summary table. All articles were re-examined for themes that were identified at the end of this process to ensure they were captured for all papers. Common themes emerged across articles. These themes were then organised into groups; themes which were relevant to adult victim-survivors at an individual level, themes which were relevant to adult victim-survivors' family, friends, community and/or culture at a social or cultural level, and themes which related to the formal support service itself at a structural level. These groups of themes led the structure of this report.

2.1 Quality assurance

Quality assurance was ensured by only including literature which specified sufficient information about the methods employed to enable the assessor of this literature review to evaluate and confirm the reliability and rigour of the methodologies used. Research was assessed based on quality and relevance. For example, research was excluded from this review where there was a lack of transparency in the methodology or the ethics, i.e. it was not clear how the data was collected, how many participants there were or how the data was analysed objectively. Small samples for the qualitative research are deemed appropriate for the research conducted given that they were conducted first-hand with adult sexual violence victim-survivors and/or support providers. Two researchers quality assured the literature for this review and findings were shared with relevant stakeholders to ensure no key literature was missed. This literature review was also peer reviewed.

Limitations

Despite the above quality assurance processes taken, as with all literature reviews, it cannot guarantee this is a complete and comprehensive review of all the literature on every topic. However, the process adopted within literature reviews, including this review, does allow a structured, rigorous and reliable search and review of the literature to be undertaken in a streamlined manner to minimise the risk that relevant literature is missed.

There are also some limitations:

- This literature review relies on existing published evidence and therefore is reliant on the interests and focus of other researchers which can limit the findings on questions of current policy interest.
- The inclusion of international literature means that care needs to be taken in applying the findings directly within the England and Wales context.
- Much of the qualitative research included in the review is drawn from small sample sizes where samples are not representative of all adult victim-survivors. Furthermore, as adult victim-survivors are a 'hard to reach' group for research purposes, sampling approaches are often not representative of all rape or sexual violence victims. Findings from individual studies therefore represent a partial picture that, alongside other research, can build our understanding on this topic. The findings in this review should therefore be read in conjunction with the findings from the quantitative survey that has been published separately and aimed to corroborate the findings from this literature review with a larger sample of adult rape and sexual violence victim-survivors.[4]
- Whilst this review aimed to examine the barriers adult victim-survivors face and their support needs, it was not always possible to distinguish between findings which related to child and adult sexual violence victim-survivors. It was also not possible to distinguish between findings by the type of sexual violence they experienced and the context it occurred in (i.e., sexual violence in the context of domestic abuse).

[4] It is important however to note that the survey sample was self-selecting and therefore not representative.

- The ten-year timespan of evidence means that some of the findings presented are dated. In addition, due to the timing of this review it is unlikely to cover the Covid-19 period (March 2020 to May 2022). The various national responses to Covid-19 are known to have impacted on the needs of victim-survivors and on support services that adapted to respond to these needs. This change has not been captured by this review.
- This literature review did not consider the support needs of frontline professional and volunteer workers who witness the trauma experienced by victim-survivors. There is existing literature on this topic (Burman, Robinson & Crowley, 2018; Choi, 201; Raunick, Lindell, Morris and Backman, 2015) which should be explored further to better understand the vicarious traumatisation service providers may face and what can be done to best support them.

3. Summary

Findings from the 54 papers are summarised in relation to each key research question below. Two separate sections summarising the evidence gaps identified within the literature review and a section on implications of findings for commissioning of support services are also provided.

3.1 Barriers to accessing support

When deciding whether to seek support, adult victim-survivors of rape and sexual violence may face barriers at individual, social and cultural levels. These include feelings of shame, self-blame and fear of community reprisal for speaking out. Should victim-survivors overcome these barriers and decide to seek support, they may then be faced with a second layer of structural barriers in relation to how a service is designed and delivered. This may make it difficult or, in some cases, impossible for them to access formal support services. It is vital that commissioners and service providers understand the key barriers that victim-survivors face at each level to enable them to design support services that victim-survivors' can access and engage with.

Findings in relation to the individual level barriers victim-survivors face in accessing support were predominately consistent across England and Wales and international literature. For example, most research papers which addressed this research question found that victim-survivors may be deterred from seeking support due to feelings of shame, self-blame and not considering the sexual violence they experienced as 'serious enough' to warrant accessing support.

The evidence in relation to the social and cultural barriers victim-survivors may face in accessing support was less consistent across research papers. This is because some studies focused solely on male, lesbian, gay, bisexual or transgender (LGBT) or ethnic minority victim-survivors; these victim-survivors may face additional social and cultural barriers related to their gender identity and/or ethnicity as highlighted throughout the review. Some of these barriers therefore did not appear consistently across research, but instead only in research reports conducted with victim-survivors with these

demographics. Some barriers are also specific to the intersecting identities of some victim-survivors.

Findings in relation to structural barriers faced by victim-survivors was predominately consistent within England and Wales, with the majority of research reporting that victim-survivors may face difficulties accessing support due a lack of availability of support services, long waiting lists and unclear referral routes. However, there was a distinct finding in relation to the cost of services that was identified in international literature that was not found in research from England and Wales. This finding was therefore omitted from the literature review as it was not considered transferable to the context of England and Wales where support and counselling can be accessed for free.

Figure 1 summarises the existing evidence identified in the literature review on the barriers that victim-survivors may face, firstly when deciding whether to seek support, and secondly when trying to access services. It is also important to highlight that some victim-survivors may face none, some, or all of the barriers identified.

Figure 1: Summary of findings on the barriers that sexual violence victim-survivors face in accessing support

Some common recommendations were made by either victim-survivors, support providers and/or authors within the identified sources in relation to overcoming these barriers:

- Increased accessibility to information and education about what sexual violence is, for example, through public education activities and outreach within communities. One specific recommendation given was the use of an anonymous online tool guiding the victim-survivors through questions and resources to provide validation, support and information for victim-survivors questioning whether their assault was 'serious enough' to seek support;
- Evidence based resources to be available on how to help a friend or family member. Unfortunately, the literature was not clear how to best make these available;
- Clear details on how to access services, including advertisements in public areas, outreach within specific communities (particularly LGBT), early education in schools and colleges and a database available to general organisations (such as LGBT organisations) of inclusive sexual violence support organisations to refer on to;
- Effective referrals to appropriate support services from GPs, police and other statutory organisations. One specific recommendation was that GPs should be trained to ask the right questions to identify sexual violence as it is not always easy for victims to disclose;
- More awareness raising around minority groups' experiences of sexual violence to ensure they recognise their experience as sexual violence;
- Clear information from support providers that victim-survivors can access support irrespective of whether they report to the police and that they are inclusive.

3.2 Adult victim-survivor support needs

The literature review identified several research studies which provide insight into what support victim-survivors may want. Overall, this mirrored practitioners' perspectives around victim-survivors' support needs, hence both perspectives were included in the review and summary.

There are some universal support needs identified for victim-survivors irrespective of their gender, sexual orientation, age, ethnicity and/or background that were found consistently across research in both England and Wales and internationally. These include a need for flexible support provided by practitioners who understand the traumatic impacts of sexual violence. However, distinct needs were also identified in research conducted with minority victim-survivors (i.e. ethnic minorities and LGBT victim-survivors). Whilst recognising the intersectionality of individuals identities, these needs are highlighted separately throughout this review.

Given that each victim-survivor's journey to building resilience is unique, changing based on victim-survivor demographics and over time, each need included in this review was not identified in every literature source. For example, some reports highlighted a need for opportunities for empowerment for victim-survivors such as through peer support, whilst in other papers this need was not raised. The most important finding in relation to what victims want is therefore the need to give victim-survivors **choice and flexibility** around what type of support they can access, who they can receive this from, and how they can receive this.

A summary of the findings on what victim-survivors want a choice of is outlined in Figure 2 below.

Figure 2: Summary of the evidence in relation to choices adult victim-survivors' want from support

What types of support do victim-survivors want a choice of?

- Immediate crisis intervention, including helplines
- Emotional support, including therapy, counselling and interventions to reduce PTSD, anxiety and depression
- Practical support, particularly for victim-survivors with insecure immigration status, who may be dealing with civil matters
- Independent Sexual Violence Advisors (ISVAs – who provide specialist tailored support to victim-survivors who have experienced rape and sexual assault, irrespective of whether they have reported to the police or not) and advocates
- Flexible combination of psychological support from NHS and specialist sexual violence support from community-based specialist sexual violence support organisations
- Support deciding whether to report to the police and support navigating the criminal justice process, the close relationships built with ISVAs and the links ISVAs had with other organisations were seen as particularly valuable
- Choice of having group support; this may be particularly beneficial whilst victim-survivors are on the waiting list to receive one-to-one counselling
- Opportunities for empowerment, including peer support and ability to help other victim-survivors

How do victim-survivors want to be able to choose support to be delivered?

- A choice of one-to-one or group therapy
- Option to access support over the phone or online
- Open-ended rather than time-limited support
- Available irrespective of whether you report to the police or not
- In a safe, professional but non-clinical setting
- Accessible to accommodate victim-survivors who do not have English as their first language or those with learning disabilities
- Variety of appointment times

Who do victim-survivors want a choice of being able to access support from?

- Practitioners who highlight that they believe them, opposed to victim blaming and judging
- Practitioners who acknowledge emotions such as shame, fear, sadness and anger and helps the victim-survivor to firstly understand these are normal reactions
- Someone who helps the victim-survivor to understand their experience and articulate it
- Someone who builds trust with the victim-survivor and makes them feel safe
- Gives victim-survivors the time and control to make their own decisions about support
- Support providers who are diverse – in their age, gender, sexual orientation, ethnicity and backgrounds
- The choice to be supported by someone they can see themselves in, this may be in relation to their gender, ethnicity, age and/or sexual orientation
- Provided by a support organisation who are responsive to the lived, social and cultural contexts (e.g. recognising gender, race, culture and ethnicity)

3.3 Effectiveness of support for adult victim-survivors

Building resilience

To ensure victim-survivors are better able to build resilience following the crime, it is not enough to ensure that they receive support – the support must also be effective. Only a limited number of studies were identified within this review within the search time period and of sufficient quality to determine what effective support looks like. Of those research studies which were identified, most looked at the effectiveness of interventions in improving mental health outcomes. The literature identified in the review was consistent in suggesting that cognitive behavioural therapies (prolonged exposure and cognitive processing therapy), eye movement desensitisation and reprocessing (EMDR) therapy, counselling and psychotherapy have a positive effective on reducing post-traumatic stress disorder (PTSD) and other psychological outcomes post-treatment. However, the scale of the effect varied between small to moderate. The research identified had different sample characteristics and utilised different methodologies (for example, varying follow-up periods to assess PTSD), therefore it is difficult to draw firm conclusions from the findings.

Engaging with support services

There was no high-quality evidence found on the effectiveness of any interventions in reducing the barriers victim-survivors face in accessing support or the effectiveness of different modes of delivering support. The reviewed studies were relying on victim-survivors expressing what they wanted as opposed to any experimental evaluation designs testing the effectiveness of different interventions.

Engaging with the criminal justice process

In relation to the effectiveness of support for victim-survivors engaging with the criminal justice process, there is some available evidence to suggest that victim-survivors supported by an Independent Sexual Violence Advisor (ISVA) and other support (such as charities) are more likely to report to the police. The two quantitative research studies identified in relation to this research question were also consistent in finding that victim-survivors who received support from an ISVA or other specialised sexual violence support service were approximately twice as likely to remain engaged with the criminal justice process. However, it is important to note that these findings are from a subset of victim-survivors and further research is needed to further test these findings.

3.4 Evidence gaps

The literature review did not identify many large-scale quantitative studies exploring the barriers victim-survivors face in accessing support and what their support needs are. Much of the literature in relation to these research questions relied on smaller scale qualitative research studies. Two key evidence gaps were therefore identified, which were sought to be addressed with the survey in the second strand of the research programme. These were: to understand the scale of each of barriers victim-survivors may face in accessing support and victim-survivors’ priorities around what formal support they want, how they want this to be delivered and by whom.

Literature in relation to the effectiveness of support was also difficult to draw conclusions from given that different studies utilised different outcome measures to determine effectiveness. There was no evidence identified in relation to the effectiveness of helplines, however this is likely due to the methodological challenges and costs associated with

doing so. More research on this area would be valuable to understand how well helplines work and what best practice in delivering helpline support is.

Another key evidence gap identified was what outcomes victim-survivors in England and Wales want when accessing support and therefore what effective looks like to them.

There was also limited evidence identified in relation to older or disabled victim-survivors' support needs. The third strand of the research programme, qualitative research with disabled victim-survivors sought to fill the latter evidence gap, however there is a need for future research directly with older victim-survivors to understand their support needs.

3.5 Implications for commissioning of support services

Based on the reviewed evidence, commissioners should consider:

1. Improving referral pathways.
Commissioners should work to improve referrals by identifying and sharing referral pathways and working with statutory agencies, such as GPs, to ensure clear referral processes are in place for victim-survivors to access sexual violence support.

2. Improving the inclusiveness of support services.
Support services being commissioned should make it clear they are inclusive through promotional materials, non-gender specific language and commissioning some 'by and for' services, particularly for ethnic minority and trans victim-survivors.[5] Commissioned services should be able to evidence an ability to engage with victim-survivors whose first language is not English and older victim-survivors. Commissioners should also ensure that commissioned support services have staff who are trained to understand the intersectional experiences minority victim-survivors face. Commissioned support services should have diverse workforces, so that victim-survivors have the option to be supported by someone who they can see themselves in.

Commissioners should encourage increased partnership working between specialist sexual violence support organisations and specialist ethnic minority/LGBT/disability/elderly

[5] Please note, while language tailored to biological women may be used for these services, there should also be clearly signposted support for victim-survivors who are male, LGBT+ and from other minority groups.

services. This should improve practitioners' understanding of both the unique impacts of sexual violence and the intersections of identities and experiences users may have.

3. Commissioning a range of support services, which meet victim-survivors needs.
Commissioners should commission support services which can evidence being trauma informed. They should continue to commission a range of support which offers victim-survivors a choice of type of support, how they access this and via whom. This is important given victim-survivors' needs change over time and are dependent on their individual characteristics.

It is also important commissioned services publish information on what happens when someone discloses to them, what information they will need to provide and the level of confidentiality and anonymity of the service.

4. Increasing the provision of group support.
The benefits of increased provision of group support for victim-survivors should be considered to allow victim-survivors to connect with others.

5. Improving monitoring and evaluation of formal support.
Commissioners should consider continuously monitoring the effectiveness of funded support services by the collection and analysis of monitoring data. They should also seek to evaluate the effectiveness of helplines.

6. Improving public and victim-survivor awareness of sexual violence and support services available to them.
There should be improved guidance for the public and informal support providers on how they can effectively and sensitively support and point victim-survivors towards formal support. This guidance should be carefully drafted with input from victim-survivors and their informal support networks. There is also a need for increased outreach activities to ensure victim-survivors are aware of support services.

4. Findings: Individual level factors

When deciding whether to seek support following sexual violence, there are individual factors relating to a victim-survivor's pre-existing knowledge and emotions that may act as barriers to seeking support. This section outlines these individual level barriers before describing what victim-survivors want in relation to each theme and detailing the existing evidence in relation to the effectiveness of emotional and psychological support.

4.1 Acknowledgement of sexual violence

Lack of acknowledgement of sexual violence as a barrier to accessing support

One of the key barriers at an individual level to seeking support identified in the reviewed literature, both in England and Wales and internationally, is a lack of acknowledgment that what victim-survivors have experienced is sexual violence and/or them not believing it is 'serious enough' to warrant accessing support (Anderson & Overby, 2020; Harvey, Mitchell, Keeble, McNaughton & Rahim, 2014; Holland & Cortina, 2020; Holland et al., 2021; Lindquist, Crosby, Barrick, Krebs & Settles-Reaves, 2016; Richardson, Armstrong, Hines & Reed, 2015; Sit & Stermac, 2021). As highlighted by one sexual violence victim-survivor (who is also a support provider) within a qualitative study conducted in the US, there is a "disconnect between what people think of when they think rape or sexual violence and what it actually is" (Anderson & Overby, 2020, p.1575) which makes some victim-survivors doubt whether they 'deserve' support. Victim-survivor respondents across two studies in the US reported that they compared their own experiences to others to determine whether they thought it was bad enough to qualify as sexual violence and therefore seek support (Anderson & Overby, 2020; Holland et al., 2021).

Whilst this lack of acknowledgement of sexual violence was found to be a universal barrier amongst respondents, the evidence reviewed suggests some victim-survivors may be more likely to face this barrier when deciding whether to access support, depending on the type of sexual violence they experienced and/or their demographics.

The reviewed evidence found there was a social acceptance of ‘less serious’[6] sexual violence amongst younger female college/university aged victim-survivor respondents in the US, which contributed to minimisation of other forms of sexual violence and some respondents therefore not seeking support (Holland et al., 2021; Lindquist et al., 2016; Holland & Cortina, 2017). These respondents reported not seeking support as they did not want to make it a big deal when it ‘could have been worse’.

Furthermore, a previous systematic review[7] based on international evidence about the barriers to sexual violence victim-survivors help-seeking behaviour (including from support services) revealed that those who knew the perpetrator, were using substances or were uninjured during the assault was less likely to acknowledge that what they experienced was sexual violence and therefore seek formal help (Zinzow, Littleton, Muscari & Sall, 2021). In contrast, victim-survivor respondents who were sexually assaulted by a stranger, experienced forcible rape or sexual assault with a weapon, experienced a co-occurring crime, were assaulted by multiple perpetrators and/or were injured during the assault were more likely to seek services (Zinzow et al., 2021).

Qualitative interviews conducted with 15 sexual assault victim-survivors in Canada, who self-identified as living in poverty, found that participants highlighted their lack of access to information about what sexual violence is and subsequently their lack of knowledge about what constitutes sexual assault meant they did not reach out for support for years, therefore delaying their journey to recovery (Sit & Stermac, 2021). The lack of access they had to information about what sexual violence is may therefore put them at an increased risk of not accessing support.

Finally, sexual violence can be viewed as a crime which predominately affects younger, heterosexual, cisgender females. Evidence from England and Wales and internationally suggests LGBT, male and/or elderly victim-survivor respondents reported not always initially acknowledging their experience as sexual violence (Bows, 2018; Chynoweth, Buscher, Martin & Zwi, 2020; Donne et al., 2017; Harvey et al., 2014). This finding is

[6] All sexual violence is serious. However, in the identified studies, they defined ‘less serious’ being those that are not forcible penetration.

[7] A systematic review is the process of systematically locating and synthesising secondary data sources to address pre-determined research questions.

expanded on in Section 5.1 of this report, where the attitudes and beliefs held in society which can act as barriers to victim-survivors seeking support are explored.

Several recommendations for overcoming the discussed barriers were given by both victim-survivors and support providers who took part in research and/or authors of the research. Based on findings from qualitative interviews with victim-survivors in the US, the researchers recommended an anonymous online tool should be available to victim-survivors to guide them through questions and resources and to provide validation, support and information for victim-survivors who were questioning whether their assault was ‘serious enough’ to seek support (Anderson & Overby, 2020). Increased awareness raising, such as through media campaigns, education and outreach around what sexual violence is and highlighting that all sexual violence is serious, was recommended in multiple papers (Holland et al., 2021; Lindquist et al., 2016; Richardson et al., 2015; Sit & Stermac, 2021; Zinzow et al., 2021). For example, victim-survivor respondents living in poverty in Canada highlighted a need for increased accessibility of information such as through formal support services engaging in more public education activities (i.e. organising support groups or information sessions within local communities) to ensure accessibility of information around what constitutes sexual assault (Sit & Stermac, 2021). Some of these participants praised similar support they received during their own journey, including being provided with information about the nature and causes of sexual assault, common impacts and skills for coping with post-assault sequelae during their own journey.

Adult victim-survivors needs in relation to acknowledgement of sexual violence

If victim-survivors do disclose what has happened to them, some respondents in England and Wales reported wanting support networks (both formal and informal) to help them to understand, acknowledge and articulate the experience (Champion, Lock, Puntan & Hendra, 2021; Hester & Walker, 2018). For example, research conducted in England and Wales found that not all respondents initially realised or accepted they had been raped, especially if they were in a relationship with the perpetrator or had previously participated in consensual sexual activity with them (Champion et al., 2021). However, seeking support from friends, family, support services or a sexual health clinic enabled them to understand the severity of the situation as it allowed them to be listened to and subsequently told it sounded like their experience was rape. Support in this way was particularly valuable for

respondents who had been in a relationship with the perpetrator. Furthermore, findings from qualitative interviews conducted with sexual violence victim-survivors and practitioners working with them in England and Wales revealed that victim-survivor respondents found ISVAs particularly valuable in helping them to acknowledge and articulate their experience in a safe and neutral place (Hester & Walker, 2018). For example, one participant highlighted that "(the ISVA) pointed out that it's been abusive relationship. Well I didn't picture it as that … now I can talk to her and if I don't understanding something, I know she will find out or explain in a way that I would understand so I realise that it's not normal behaviour" (Hester & Walker, 2018, p.7). It was deemed important that the ISVA invested time at this initial stage when accessing support to help the victim acknowledge the abuse and understand their emotions so they could identify each victim-survivors individual needs and facilitate access to relevant services for them to recover.

4.2 Emotional and psychological factors

Emotional and psychological barriers to accessing support, including shame, self-blame, trauma and fear

The literature review found evidence, both in England and Wales and internationally, which showed that victim-survivors who participated in the research, irrespective of their demographics, often reported experiencing feelings of shame, which can act as a barrier to them seeking support (Anderson & Overby, 2020; Chynoweth et al., 2020; Harvey et al, 2014; Holland & Cortina, 2017; Hutschemaekers, Zijlstra, de Bree, Lo Fo Wong & Lagro-Janssen., 2019; Rymer & Canessa-Pollard, 2017; McDonald & Tijerino, 2013; Sit & Stermac, 2021; Thiara & Roy, 2020; Richardson et al., 2015). This shame was often found to be underpinned by self-blame whereby respondents reported feeling they invited the assault, with some questioning why it happened to them specifically and what they could have done to prevent the assault (Anderson & Overby, 2020; Hutchemaekers et al., 2019; Thiara & Roy, 2020). Experiencing self-blame, particularly amongst college-aged respondents, tended to be more likely when they had been intoxicated at the time of the assault, suggesting rape myths[8] are also influencing some victim-survivors' decisions

[8] Rape myths can be described as prejudicial, stereotyped, false beliefs about sexual assaults, rapists, and rape victims

around whether to seek support (Richardson et al., 2015). This is demonstrated in a quote from a US study, whereby one college-aged female victim-survivor noted “I knew I shouldn’t have been drinking as much as I was at the time. It was partially my fault” (Holland & Cortina, 2017, p.56). In research conducted with 36 BME victim-survivors in England and Wales, it was reported that victim-survivor respondents who were abused by different men, their partner or a trusted family member and those who did not receive support were more likely to report experiencing feelings of shame and self-blame (Thiara & Roy, 2020).

Both in England and Wales and internationally, the shame discussed by many victim-survivor respondents was closely linked to a fear of not being believed by service providers; a fear which was found to deter some respondents from seeking support (Anderson & Overby, 2020; Richardson et al, 2015; Rymer & Canessa-Pollard, 2017; Thiara et al., 2015; Thiara & Roy, 2020). Qualitative interviews conducted with 42 trans* victim-survivors in England and Wales found that some respondents were fearful that their experience of sexual violence would be viewed as a result of their gender identity and therefore they would not be believed or even blamed; this fear acted as a barrier to them seeking support (Rymer & Canessa-Pollard, 2017). Research conducted with 19 victim-survivors in the US, who also worked as sexual violence support providers themselves, highlighted a fear that service providers would not be sufficiently trained to support them and therefore make the support feel discouraging and blaming as opposed to helpful (Anderson & Overby, 2020). Other fears which were reported in the reviewed evidence include fear of the perpetrator causing further harm to themselves or their family and, for respondents with insecure immigration status, fears of being deported and/or losing their children (Harvey et al., 2014; Thiara & Roy, 2020).

The review also found that some victim-survivor respondents in the US and Northern Ireland were deterred from seeking support due to the negative emotions and trauma associated with the sexual violence they experienced (Anderson & Overby, 2020; Donne et al., 2017; Walshe, 2020). One male victim-survivor participant reported that they did not want to think about the event to avoid feeling distressed and therefore avoided seeking support so that they did not have to bring up negative emotions (Donne et al., 2017). This finding was echoed in research conducted in Northern Ireland, with some victim-survivor

respondents reporting not wanting to relive the experience as a barrier to seeking support, whilst other respondents described the difficulty of seeking help in a state of psychological distress (Walshe, 2020). One victim-survivor highlighted, “I was in a fog for a long time. I didn’t sleep at all for a couple weeks like I just wasn’t functional” (Walshe, 2020, p.162). Their ability to seek help was impacted by their mental health as they were unable to discern what services they needed.

Adult victim-survivors support needs in relation to emotional and psychological support

To address the self-blame and shame experienced by some victim-survivor respondents, if they did decide to seek support (whether this was informal or formal), respondents in England and Wales and internationally reported benefiting from being listened to without judgement and being told by the support provider that they are believed (Hutschemaekers et al., 2010; Kirkner, Lorenz & Ullman, 2021; Ranjbar & Speer, 2013; Rymer & Canessa-Pollard, 2017; Thiara & Roy, 2020). Some victim-survivors who participated in research reported that it was important to them that support providers acknowledged emotions such as shame as normal following disclosure, so that the victim-survivor could be reassured (Hutschemaekers et al., 2010). Some victim-survivor respondents highlighted that they were disappointed when service providers did not acknowledge their fear, sadness and anger. In one study conducted in England and Wales, it was suggested that addressing internalisation and self-blame was more effective in one-to-one, as opposed to group, therapeutic support, as it allowed victim-survivors to talk more openly (Thiara & Roy, 2020). Qualitative findings from a survey conducted with 27 victim-survivors in England found that victim-survivors’ recovery was impeded when health care professionals adhered to rape myths and stereotypes and/or were disrespectful or inconsiderate when treating victim-survivors (Ranjbar & Speer, 2013). Participants emphasised the importance of being believed by others in their recovery and described respectful treatment, such as the provider being sensitive and caring during medical treatment, as important in reducing feelings of shame.

It was also highlighted by some respondents that they wanted the support provider to “engage in supportive listening, without displaying pity or giving the appearance of trying to rescue the survivor” (Kirkner et al., 2021, p.1016), with one respondent reporting the most

helpful response they had was being reassured that it was not their fault and being supported in counteracting rape myths when they disclosed. This is considered standard practice in victim advocacy agencies, reaffirming its importance.

As many victim-survivors accessing support services will experience some response to trauma, the need for trauma-informed practice in supporting victim-survivors so as not to further traumatise or deter them from accessing support was also highlighted across literature in England and Wales and internationally (Australian Institute of Family Studies, 2017; Champion et al., 2021; Hester & Walker, 2018; Thiara & Roy, 2020; The Survivors Trust & Rape Crisis, 2015). Whilst there are several definitions of trauma-informed care, the Mental Health Coordinating Council (2013) in Australia highlights that "trauma-informed care and practice is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics" (Mental Health Coordinating Council, 2013, p.9). Furthermore, it is suggested there are nine core principles of trauma-informed care commonly cited in literature which include safety, trust, choice, collaboration, empowerment, promoting healing relationships, understanding culture, knowledge and staff wellbeing (QCDFVR, 2020).

Victim-survivor respondents in England and Wales highlighted that they want to be supported by providers who have an understanding of trauma-informed recovery, rather than supported by practitioners with a lack of understanding of working with sexual violence victim-survivors, who may come across as insincere, disinterested or see trauma recovery as a linear process (Champion et al., 2021). When respondents were supported by a provider with an understanding of trauma-informed recovery, they reported finding it "extremely helpful and validating" (Champion et al., 2021, p.77). Based on this, one of the main suggestions given to improve support was improving third sector funding to increase the availability of specialist services in a timely manner. Victim-survivors who participated in research in England and Wales also highlighted the importance of the issue being recognised as trauma and not an illness and to be supported in regaining control of their life (The Survivors Trust & Rape Crisis, 2015). The importance of victim-survivors needing to be given the time and control to make decisions during their recovery was also raised by both victim-survivor respondents and practitioners working with them in research in the US

(Anderson & Overby, 2020). It has been recommended that ongoing cross-sector training should ensure services available to victims are trauma informed (Australian Institute of Family Studies, 2017; The Survivors Trust & Rape Crisis, 2015).

Closely linked to the need for trauma-informed care, specialist rather than general support was deemed important by many victim-survivor respondents in England and Wales to support their emotional needs and the unique impacts of sexual violence (Champion et al, 2021; Hester & Walker, 2018; Thiara & Roy, 2020). The Survivors Trust and Rape Crisis England and Wales define specialist sexual violence services as those whose primary purpose is to address, prevent and tackle sexual violence and support survivors (The Survivors Trust & Rape Crisis England and Wales, 2015). Victim-survivor respondents highlighted that receiving specialist rather than general support allowed them to feel hopeful rather than hopeless and helped them to build self-esteem (Thiara & Roy, 2020). Some victim-survivor respondents who were referred to both general NHS mental health support and specialist sexual violence support reported that they preferred specialist sexual violence services as sexual violence was discussed directly, rather than just treating mental health symptoms (Hester & Walker, 2018). They highlighted that specialist sexual violence support services were critical in providing counselling, emotional support for court appearances, practical help and links to other agencies. However, other victim-survivor respondents noted that they welcomed a flexible combination of psychological support provided by general NHS support and specialist support provided by an ISVA (Hester & Walker; 2018; Scott et al., 2015). They highlighted that this helped to address their changing needs over time. For example, the psychologist was able to help with their depression while specialist support enabled them to report to the police and allowed them to be referred on to more specialised sexual violence counselling services to deal with the complexity of the emotions the victim-survivor faced (Hester & Walker, 2018). However, LGBT respondents in Wales highlighted that there is a gap in provision of specialist services and a lack of understanding of LGBT victim-survivors experiences within existing specialist sexual violence services (Harvey et al., 2014). It was therefore suggested to investigate, on a small scale, the value of providing specialist LGBT workers in sexual violence services and/or specialist domestic and sexual violence (D/SV) workers in LGBT services. Similar findings were found in research with BME victim-survivors in England and Wales, where it was suggested that close partnerships between specialist sexual violence

support organisations and specialist BME services would be valuable and that all practitioners at services should be aware of the intersections of identities and experiences service users may have (Thiara, Roy & Ng, 2015; Thiara & Roy, 2020). As one victim-survivor clearly outlined,

> “there needs to be both so women have a choice as we are always going to see women that will want to access a specialist BME service and therefore I think it’s really important that BME women’s services are able to respond to sexual violence. But I also think that there will always be women that will prefer to access mainstream services as well so they should get an appropriate response within a mainstream [sexual violence] service” (Thiara, Roy & Ng, 2015, p.26).

Victim-survivors who took part in research across England and Wales and internationally reported wanting timely access to a choice of psychotherapy and counselling to support them emotionally and psychologically, including immediate crisis counselling as well as longer-term emotional support (Australian Institute of Family Studies, 2017; The Survivors Trust & Rape Crisis England and Wales, 2015; Thiara & Roy, 2020; Champion et al., 2021). Some victim-survivor respondents in England and Wales reported finding holistic, person-centred support which focused on the survivor and their wellbeing as opposed to only on the criminal justice case or rape, particularly helpful (Champion et al., 2021). One of the key suggestions offered by victim-survivor respondents to improve support was ensuring they are offered a choice of psychotherapy and counselling. Research with practitioners who support minority victim-survivors in England and Wales reported that some women did not engage or benefit from western models of counselling. Instead, they wanted more fluid forms of counselling that are relevant to their lived contexts, such as group support through arts-based or social network building activities and the ‘by and for’ approach (Thiara & Roy, 2020).[9] They highlighted that therapeutic work which supports both emotional and practical needs has particular value for women with insecure immigration status or who may be dealing with civil matters.

Other findings from research conducted with victim-survivors provided insight into what types of support victims want to promote recovery and emotional wellbeing, which were

[9] ‘By and for’ services are those which are run by providers who have the same background and characteristics as the victim-survivors they are supporting

consistent across research conducted in England and Wales and internationally. These include being supported by someone who is caring, compassionate, understanding and who takes their needs and concerns seriously (Fehler-Cabral et al., 2021; Walker et al., 2019). Choice was another aspect victim-survivor respondent reported wanting in England and Wales and intentionally, both in terms of choice in the type of support they want to access and how they want this to be delivered (i.e. a choice of female or male support worker) (Champion et al., 2021; Fehler-Cabral et al., 2021; Gagnon, Wright, Srinivas & DePrince, 2018; The Survivors Trust & Rape Crisis England and Wales, 2015; Thiara, Roy & Ng, 2015). For example, victim-survivor respondents in the US reported valuing when sexual assault nurse examiners gave them time and choice over if, how and at what pace they wanted to take the forensic examination process (Fehler-Cabral et al., 2011).

Effectiveness of emotional and psychological support

There were a limited number of high quality and relevant articles identified exploring the effectiveness of emotional and psychological support internationally (Garry and Munro, 2020; Littleton, Grills, Kline, Shoemann & Dodd, 2016; Nixon et al., 2016; Rothbaum et al., 2013; Schwarz et al., 2019; Tarquinio et al., 2012; Vieweger, 2019; Miller, Cranston, David, Newman & Resnick, 2015; Westermarland and Alderson, 2013). Of those which were identified, the majority explored the effectiveness of psychological interventions in improving mental health outcomes, such as PTSD symptoms. Other outcomes considered in the research included: feel empowered and in control of their life; have flashbacks about what happened; have panic attacks; use alcohol to help them; feel depressed; have thoughts about ending their life; feel well enough to work or study; have a fear of phobia that prevents them from doing everyday tasks; feel responsible for what happened to them; over-eat, under-eat or use food as a means of control; self-harm to help cope with feelings; and use non-prescribed drugs to help cope.

Within the identified literature, there is some limited evidence to suggest that the following forms of interventions are able to reduce PTSD and other psychological outcomes in the short-to-medium term (up to 1 year) post-treatment. It is important to note at this stage, however, that further research is required to conclude the effectiveness of emotional and psychological support in supporting victim-survivors, particularly in relation to what works for different groups of victim-survivors and what works in the longer term.

Cognitive behavioural therapies (including prolonged exposure and cognitive processing therapy)

The identified evidence suggests cognitive behavioural therapies, based on the concept that your thoughts, feelings, physical sensations and actions are interconnected (NHS, 2021), are effective in improving mental health outcomes for victim-survivors who participated in research outside of England and Wales (Littleton et al., 2016; Nixon et al., 2016; Rothbaum et al., 2013).

In Australia, 47 victim-survivors with acute stress disorder were randomly allocated to receive either cognitive processing therapy (CPT, *N*=25) or treatment-as-usual from a community sexual assault centre (*N*=22) (Nixon et al., 2016). Those in the CPT condition received six 90-minute sessions which included introducing cognitive restructuring techniques and introducing victim-survivors to alternative ways of thinking. The treatment-as-usual condition received a range of psychoeducation, supportive counselling, mindfulness and discussion of thoughts and feelings. Both groups were assessed at pre-treatment, post treatment, 3, 6 and 12 months follow ups for PTSD, anxiety, depression and substance abuse disorders. The findings revealed that, although both treatments led to post-treatment improvements, larger increases were seen on some measures for CPT. For example, assessment of PTSD severity indicated more CPT participants reached good end-state functioning at the 12 months follow-up than those in the treatment-as-usual condition. The findings therefore suggest CPT or treatment-as-usual approaches can be effective as an early intervention for some victim-survivors.

In the US, 87 college women with PTSD as a result of rape were randomly allocated to receive an interactive, online, therapist-facilitated cognitive behaviour programme (From Survivor to Thriver programme) or a psycho-educational self-help website (Littleton et al., 2016). The findings revealed that both programmes led to reductions in interview-assessed PTSD post-treatment and at 3 months follow-up. Victim-survivors who took part in the research also reported decreased depressive and anxiety symptoms post-treatment. Follow-up analysis revealed that the ‘From Survivor to Thriver’ programme was more effective for those who had higher pre-treatment PTSD, whereas the psycho-educational self-help website was more effective for individuals with lower pre-treatment PTSD.

Promising evidence has also been found in the US with the use of a modified prolonged exposure (PE) treatment delivered to women (*N*=28) presenting at an emergency department within 3 days of a sexual assault (Rothbaum et al., 2013). Compared to a control treatment who did not receive treatment, those who received modified PE (including breathing relaxation techniques, self-care strategies, attention to cognitions and repeated exposure to trauma narrative to allow for fear extinction) reported significantly less PTSD 4 weeks post-treatment.

Eye movement desensitisation and reprocessing (EMDR)

Promising evidence has been found in relation to the impact of EMDR on improving mental health outcomes for victim-survivors who took part in the research in the Netherlands and France (Schwarz et al., 2019; Tarquinio et al., 2012). Within EMDR, a scene is used to represent the entire rape trauma; the victim-survivor imagines the scene and recites words related to the scene whilst the therapist moves their fingers back and forth in front of the survivor, so the survivor performs quick simultaneous movements of the eyes between two fixation points by watching the therapist's fingers. This movement is thought to facilitate the processing of trauma memory through the attention needed to both move the eyes and process the trauma scene. When the victim-survivors anxiety to the scene has decreased, a new adaptive belief is rehearsed until this new belief feels true.

In the Netherlands, a randomised control trial (RCT)[10] was conducted to assess the effectiveness of early intervention of EMDR therapy to reduce symptoms of PTSD, feelings of guilt and shame, sexual dysfunction and other psychological dysfunction including anxiety and depression in victim-survivors (Covers, 2021). Fifty-seven victim-survivors of rape were randomly allocated to receive either two sessions of EMDR therapy or treatment-as-usual (which included 'watchful waiting' whereby two telephone contacts of approx. 30 mins with a sexual assault centre practitioner who provided psychoeducation, active listening and well-informed advice, whilst screening for PTSD and referring on for evidence-based treatment if appropriate[11]) between 14 and 28 days after the incident.

[10] A randomised control trial is a method in which participants are randomly assigned to one of two groups: an experimental group receiving the intervention being tested and another comparison group

[11] For the purpose of the study, typically victim-survivors were not immediately referred on but instead referred at the end of the study if necessary. If they did need to be referred on for treatment as a matter of urgency, they were excluded from the study.

Psychological symptoms were assessed pre- and post-treatment and these symptoms were compared between the two conditions. The findings revealed that whilst both were effective, EMDR was no more effective than watchful waiting in reducing PTSD, general psychopathology, depression, sexual dysfunction and feelings of guilt and shame. EMDR was found to be more effective at reducing anxiety and disassociate symptoms, however this effect was not maintained over time. The findings did provide evidence that EMDR was as effective as treatment-as-usual for participants and a safe option of treatment.

In France, researchers aimed to test the effectiveness of early treatment using EMDR in reducing PTSD and psychological distress (Tarquinio et al., 2012). Seventeen female victim-survivors of rape were given psychoeducation on the impact of sexual trauma and one session of EMDR between 24 and 72 hours after the rape occurred. The findings revealed a significant improvement in PTSD symptoms post-treatment. However, these positive changes were not significant at 6 months follow-up. The study therefore provides evidence for the effectiveness of EMDR in the short-term for these victim-survivors, however the evidence is weak given there was no comparison group used in the study and it relied on pre- and post-group comparisons.

Twenty-one adult female victim-survivors at a non-profit agency in the US completed 8 sessions of EMDR, pre- and post-assessments and an in-person interview to assess the effectiveness of EMDR for women who experienced trauma due to sexual or domestic violence (Schwarz et al., 2019). Analysis of the pre- and post-assessment data revealed a statistically significant improvement in levels of depression, anxiety, PTSD and overall wellbeing symptoms after completing EMDR. Qualitative interviews confirmed these findings, with participants reporting engaging in EMDR enhanced the therapeutic process, decreased depression and increased confidence and hope.

Counselling

Counselling is also considered effective in England and Wales and internationally (Garry & Munro, 2020; Vieweger, 2019; Westermarland & Alderson, 2013). However, there are many different models of counselling, many of which, to our knowledge at the time conducting this review, have not yet been effectively evaluated and published.

In 2013, research was conducted in England and Wales to develop and pilot a tool called the 'Taking Back Control' tool that measured the impact of Rape Crisis counselling on victim-survivors health, mental health and wellbeing (Westmarland & Alderson, 2013). The 15-item tool was developed based on a review of existing tools being used to measure depression, anxiety and wellbeing, and interviews with Rape Crisis Centre staff, local funders and commissioners. The 15-item tool measured the extent to which victim-survivors: feel empowered and in control of their life; have flashbacks about what happened; have panic attacks; use alcohol to help them; feel depressed; have thoughts about ending their life; feel well enough to work or study; have a fear of phobia that prevents them from doing everyday tasks; feel responsible for what happened to them; over-eat, under-eat or use food as a means of control; self-harm to help cope with feelings; and use non-prescribed drugs to help cope. The tool was administered by the victim-survivors' counsellor either on week one or two of receiving support and then every six weeks thereafter. The findings revealed that counselling had the largest improvement on the extent to which victim-survivor participants felt empowered and in control of their lives; 61 per cent strongly/disagreed at the start of counselling compared to 31 per cent at the last data point collection. There was also a large reduction in the extent to which participants reported having flashbacks and panic attacks. Other measures all saw some degree of positive change. It is important to note that this study provides insight into the outcome measures used to measure impact and provides an initial evidence base into the benefits of rape crisis counselling but does not provide a thorough evaluation of the services provided.

In 2020, the Rape and Sexual Violence Project (RSVP) published an initial report on the impact of their adult counselling service for survivors (Garry & Munro, 2020). RSVP provides person-centred support to victim-survivors to make links between mental health problems and childhood abuse experiences. Victim-survivors who took part in the programme completed an initial wellbeing survey at an assessment session and then counsellors completed wellbeing surveys with them at weeks 1, 8, 16 and 23 of receiving support. There were 9 measures used to assess victim-survivor wellbeing: increased confidence, better able to cope, feeling hopeful, more able to make decisions, feeling listened to, feeling safe, ability to trust, more sociable and improved relationships. For three of the measures – improved confidence, ability to cope and decision-making –

more than 50 per cent of clients reported positive outcomes. Figures for increased sociability and improved relationship and other measures were slightly lower, but still showed an increase. As highlighted within the report, this is likely due to the need for victim-survivors to be supported in improving their own confidence and coping before they are ready to look outwardly towards social relationships.

Semi-structured interviews were conducted in South Africa with 15 female rape victim-survivors to understand their experiences of counselling (Vieweger, 2019). It was found that victim-survivors valued receiving counselling in a professional safe space where they felt safe and comfortable. They wanted to receive support in a non-judgemental and confidential way that did not further stigmatise them. Victim-survivors emphasised the need to be able to talk and be heard by an empathetic listener who validated their experiences, and reported valuing the feminist counselling model whereby they were empowered to actively seek answers and solutions themselves. Finally, they noted that being able to participate in a support group enabled them to feel less alone. The findings provide insight into how victim-survivors want to be supported and should be carefully considered by support services. For example, it highlights the need for counselling to be a collaborative process which is guided by the counsellor but led by the survivor to enable empowerment and should be delivered in an environment that feels safe, but professional.

Psychotherapy (including psychoeducation)

One study identified also suggested that psychotherapy, including psychoeducation, is effective in improving mental health outcomes for victim-survivors (Miller et al., 2015). In research conducted in the US, 164 female sexual assault survivors receiving forensic examinations were randomised to receive either standard case or a brief video-based intervention after their medical examination (Miller et al., 2015). The video provided psychoeducation on reactions to sexual assault, modelling of coping strategies, targeting avoidance and strategies to improve mood. The participants completed mental health assessments 2 weeks and 2 months after the examination. The findings revealed that women who received the psychoeducational video had fewer symptoms of anxiety at the follow-up assessments. The findings therefore support the use of the video intervention to support victim-survivors who receive a forensic examination.

4.3 Implications for commissioning support services

Based on the available evidence, commissioners should consider:

1. **Improving the inclusiveness of support services.**

   Commissioners should encourage increased partnership working between specialist sexual violence support organisations and specialist ethnic minority/LGBT+/disability/elderly services. This should improve practitioners' understanding of both the unique impacts of sexual violence and the intersections of identities and experiences users may have.

2. **Commissioning a range of support services, which meet victim-survivors needs.**

   Commissioners should commission support services which can evidence being trauma-informed, so as not to further traumatise and deter victim-survivors from accessing support. They should continue to commission a range of support which offers victim-survivors a choice of type of support, how they access this and via whom. This is important given victim-survivors' needs change over time and are dependent on their individual characteristics.

   They should commission a range of support including support which can evidence effectively providing immediate crisis counselling, as well as longer term emotional support and psychotherapy. A variety of counselling models should be commissioned, as opposed to counselling based on western models of counselling, to ensure they are effective for minority victim-survivors. They should also commission support services which can evidence experience of effectively helping victim-survivors to understand, acknowledge and articulate their experience. As ISVAs were considered particularly effective in enabling this, where possible victim-survivors should have access to an ISVA, should they need one.

3. **Improving monitoring and evaluation of formal support.**

   Commissioners should consider continuously monitoring the effectiveness of funded support services such as counselling and group work through the collection

and analysis of monitoring data. They should also seek to evaluate the effectiveness of helplines.

4. Improving public and victim-survivor awareness of sexual violence and support services available to them.

There is a need for improved awareness-raising around what sexual violence is, and that all sexual violence is serious, through education and outreach. This should increase engagement with formal support services.

5. Findings: Social and cultural factors

In addition to individual level barriers faced by some victim-survivors when deciding whether to access support, they may also face barriers at a social and cultural level. These include gender and age stereotypes, cultural expectations, fear of reprisal from their community and initial reactions from informal support networks upon first disclosure. The evidence highlights what respondents reported wanting in terms of support and how it is delivered at each of these levels.

5.1 Social factors

Social barriers to accessing support

Evidence from Northern Ireland suggests informal support networks, such as negative reactions from family friends upon first disclosure, can act as barriers to accessing formal support (Walshe, 2020). Some victim-survivors who participated in research reported that they were met with disbelief, doubt or even victim blaming when they disclosed to friends and family, which led to them believing that, if their friends and family didn't believe them, then formal support wouldn't either. In some instances, this deterred them from seeking formal support. It was also found in the US that peers' reactions to disclosures of sexual abuse were linked to the level of minimisation following sexual violence; when peers minimised the assault themselves (i.e. saying it wasn't that serious or that it happens to others), this acts as a barrier to the victim-survivor seeking support (Holland et al., 2021).

Negative social implications of disclosing sexual violence was also found to deter some victim-survivor respondents from seeking support (Walshe, 2020). Some victim-survivors reported not wanting to disclose sexual violence as they wanted to maintain relationships or social structures, with one victim-survivor reporting they did not speak out "because of the implications that it would have had for him in the workplace – we work together. So it wasn't something I could freely disclose" (Walshe, 2020, p.137).

International research suggests that male victim-survivor respondents may also face additional distinct barriers in accessing support due to masculinity norms and social stereotypes, such as the expectation to appear strong and unemotional, meaning they do

not want to appear weak by disclosing the abuse (Chynoweth et al., 2020; Donne et al., 2017; McDonald & Tijerino, 2013). As clearly articulated by one male victim-survivor respondent, "there is a societal taboo about men getting help, in general, and also about men being victims, so it's a double-edged sword, and it's very hard" (McDonald & Tijerino, 2013, p.20). Another male respondent highlighted that society expect men to defend themselves, therefore making it hard to disclose abuse. Further qualitative research conducted with male victim-survivors in the US found that men may not discuss sexual violence as they are not given systems to process their emotions and trauma. Male refugee victim-survivor respondents highlighted concerns around the confidentiality of support services; they were deterred from seeking support for fear of their community finding out about what happened to them and subsequently experiencing social stigma and sanctions such as being shunned, humiliated and ostracised from the community (Chynoweth et al., 2020).

Evidence from research in England and Wales and internationally suggests that LGBT+ victim-survivors may also face additional distinct social barriers to accessing support (Donne et al., 2017; Harvey et al., 2014; Love et al., 2017). It was highlighted that LGBT victim-survivors may not view their experience as abuse because sexual violence tends to be discussed as an issue which affects heterosexual, cisgender individuals (Harvey et al., 2014). This myth that LGBT+ individuals cannot be victims of sexual violence was identified by LGBT+ victim-survivor respondents as one of the key barriers to seeking support. LGBT+ respondents also highlighted LGBT+ victim-survivors may also fear violence and abuse from people in their community if they seek help, therefore deterring them from doing so. A service provider discussed a case where they experienced the community taking the perpetrator's side over the victim-survivor's and another suggested if BME LGBT people disclose abuse in a same-sex relationship they risk facing honour-based violence or forced marriage. LGBT+ respondents also highlighted concerns around the confidentiality of support services deterring them from accessing support (Donne et al., 2017; Harvey et al., 2014; Love et al., 2017; Rymer & Canessa-Pollard, 2017). Support providers suggested that LGBT victim-survivors who are not 'out' or comfortable with their sexuality or gender identity, as well as those undergoing gender transitions, would face additional barriers in accessing services due to concern around disclosing their sexual orientation or gender identity to the support provider and fear of this information leaking

out into the community (Harvey et al., 2014). It was felt that the size of the community a victim-survivor comes from can determine whether they seek support, due to fears of being 'outed'. Victim-survivor respondents also highlighted that the stigma associated with sexual violence and being gay acted as a barrier to disclosing, with one victim-survivor stating, "they don't think it happens and if it does it's because you're gay and you desire it" (Donne et al., 2017, p.7). Furthermore, it was found that trans victim-survivors may face stereotypes that make it harder for them to get help they deserve (Gooch, 2011). These include stereotypes such as that a trans person must have deceived the perpetrator about their gender or that trans women should be able to physically defend themselves from sexual violence, leading to victims being treated like perpetrators.

Research conducted with practitioners who support older victim-survivors in England and Wales revealed that ageist beliefs and attitudes can act as a barrier for older victim-survivors in accessing support (Bows, 2018). This is based on the rape myth that rape is linked to sexual desire, together with perceptions of older people as sexually undesirable, and these myths were found to make it difficult for victim-survivors to acknowledge their experience. Support providers raised that it was important for support providers to assist victim-survivors to understand and acknowledge their own experiences. It was felt that the lack of awareness of sexual violence alongside ageist attitudes depicting older people are vulnerable, frail and undesirable created barriers to providing support to them. It was also felt that social norms formed in early life among older victim-survivors deterred them from thinking, discussing or disclosing sexual violence, increased their feelings of shame and anxiety and created barriers to seeking support. One support provider who worked with older victim-survivors noted that, "the whole process is horrific and for an older woman, having swabs and people coming and looking at your body. There is a different embarrassment attached to it when you are young" (p.1078). Research conducted in Ireland also revealed that two older victim-survivors, although aware of Rape Crisis Centres, stated they were unaware services were available to them (Scriver, Mears & Wallace, 2013). For example, one participant believed the centres only dealt with recent victim-survivors, whilst another believed they only provided support for younger victim-survivors who had experienced stranger rape, rather than by themself as an older victim-survivor.

Social support needs of adult victim-survivors

Some victim-survivors who participated in research in The Netherlands reported needing those close to them to encourage them to seek support, as they felt incompetent to act or tended to deny what had happened to them (Hutschemakers et al., 2019). As informal support networks can influence whether victim-survivors seek formal support, there is a clear need for them to have an understanding of the impact of sexual violence to enable them to respond to disclosures in a positive way (Walshe, 2020). Therefore, there is a need for awareness raising on this topic so that friends and family members are able to identify signs of distress and signpost victim-survivors to support services (Hutschemaekers et al., 2019; Walshe, 2020). Useful resources are already available for family and friends of victim-survivors, however to our knowledge these have not been evaluated for their effectiveness, likely due to the difficult nature of doing so.

Evidence from England and Wales and internationally also found that victim-survivor respondents reported a need for support in overcoming the outlined stereotypes and expectations to improve engagement with support services. It was recommended by some male victim-survivor respondents that support providers can assist male victim-survivors by highlighting the role of consent to minimise feelings of blame and shame in men and to ensure that they acknowledge their experience is abuse (Donne, 2017). Outreach directly targeting stereotypes around who can be raped and masculinity norms and support practitioners being grounded in the lived realities of gay men were also recommended to encourage male victim-survivors, who are both heterosexual and gay, to seek support. LGBT victim-survivor respondents reported wanting similar outreach and awareness raising of LGBT individuals' experiences of victimisation so that other LGBT victim-survivors can identify what they experienced as abuse (Harvey et al., 2014). Participants recommended that more active engagement than just putting a poster up is required to raise awareness, with one support provider suggesting a human rights approach addressing issues of honour and shame would be more successful. The need for confidentiality services was also raised. One specific suggestion for LGBT victim-survivors was to encourage service providers to publish information on what happens when someone discloses to them, what information they will need to provide and the level of confidentiality and anonymity of the service (Harvey et al., 2014). It was also important to victim-survivor respondents that they were able to access support through the phone,

where they would not have to disclose their gender identity if they did not wish. Furthermore, it was suggested that support offered to older victim-survivors should be sensitive to the stigma associated not only with sexual abuse but also with older age and nudity. One specific recommendation given by an existing support provider to make victim-survivors more comfortable was reducing the age difference between the victim-survivors and the clinical practitioner supporting them (Bows, 2018).

At a social level, some victim-survivor respondents in England and Wales and Canada also reported wanting to be able to connect with other victim-survivors (Burrowes, 2013; Sit & Stermac, 2017). Victim-survivor respondents highlighted valuing being able to share their experiences within women's support groups, such as those offered at rape centres. They noted that the mutual sharing of experiences was healing as it made them aware that sexual assault was a shared experience rather than individual and helped to destigmatise their experience, alleviating feelings of shame and self-blame. Furthermore, hearing other victim-survivors talk about their experience and journey to recovery gave them hope for their own. As respondents began seeing their own experiences as sources of hope for others, they wanted more opportunities for empowerment and therefore engaged in outreach and advocacy work themselves to help others. Victim-survivor respondents who attended group Gestalt therapy[12] whilst on the waiting list for one-to-one support found the group context of support was effective (Burrowes, 2013). They reported that being in a group reduced their sense of being alone and provided them with ongoing social support. They learned new ways of understanding their behaviour in the group therapy, which gave them hope that they could eventually do something about it. They also reported being able to see things from a different perspective and therefore felt better prepared for starting their one to one therapy.

More evidence in relation to ensuring services are inclusive for all victim-survivors is included in Section 6.3.

[12] An experimental form of psychotherapy that emphasises personal voice and the present moment, including sessions learning about the brain and trauma, awareness raising and exercises such as learning about the window of tolerance

5.2 Cultural factors

Cultural barriers to seeking support

The evidence suggests some victim-survivors in England and Wales and internationally may also face cultural barriers to support seeking (Hester et al., 2012; Long & Ullman, 2013; Thiara, Roy & Ng, 2015; Thiara & Roy, 2020). Research highlighted concerns around BME women's experiences being viewed as the same rather than diverse, or as linked to language, poverty or immigration. It was felt the limited cultural understanding could introduce stereotypes and assumptions about victim-survivors needs and result in discriminatory practice, acting as a barrier to victim-survivors accessing services (Thiara, Roy & Ng, 2015).

It was also found in research with BME victim-survivors in England and Wales that their family and community can create a fear of disclosing due to fear of reprisals and stigmatisation from their communities and fear of bringing family shame (Thiara, Roy & Ng, 2015). In the US, female victim-survivors who participated in the research reported adopting the persona of the 'strong Black woman' and sought to cope with their victimisation without formal support (Long & Ullman, 2013). One participant noted that they didn't seek mental health support following victimisation because they didn't think they had a problem, based on the assumption that she was not the type of person who would need therapy. Others reported not seeking help for their mental health due to previous negative experiences with mental health professionals. Similar findings were echoed in more recent research conducted with minoritised victim-survivors in England and Wales (Thiara & Roy, 2020). It was found that some victim-survivor respondents reported that they kept silent due to a fear of being seen as 'damaged' by their community in a culture that may idealise sexual purity. Many also did not access support due to the normalisation of sexual violence in intimate relationships. For some female South Asian respondents there were cultural taboos which prevent disclosure. Participants noted concerns about betraying others delayed them speaking out about sexual violence. For example, some felt that because of their race and intersectional discrimination, they had a duty to protect their community and race. They did not want to reinforce representations of minoritised communities and men so delayed seeking support. It was also found that Black Caribbean victim-survivors with whom practitioners worked with in particular did not want to talk about

the sexual violence due to fear of not being seen as strong. One participant noted, “I have always been able to be strong, and I didn’t want people to see that side of me” (Thiara & Roy, 2020, p.28). Participants also spoke about generations of women in their family being seen as strong and therefore not wanting to go against this by showing weakness. This resulted in some victim-survivors trying to cope on their own.

Language barriers were also raised as a cultural barrier to victim-survivor respondents accessing support, meaning some victim-survivors are not confident accessing services (Hester et al., 2012; Love et al., 2017; Thiara, Roy & Ng, 2015).

Support needs in relation to cultural factors

When BME victim-survivors do decide to seek support, some reported wanting to be supported by a service provider they could see themselves in (Thiara & Roy, 2020). They want to be able to communicate in their own language and relate to others supporting them, as well as to other victim-survivors within the service. Where this happens effectively, victim-survivor respondents reported being given a sense of safety and removed their fear they would not be understood. It helped women to feel less isolated and provided opportunities to form supportive friendships, which assisted in their healing and recovery. The importance of BME victim-survivors being supported by providers who are trained in understanding BME women’s experiences and for organisations to scrutinise their existing practices was also highlighted in research in England and Wales (Thiara, Roy & Ng, 2015). Additional research highlighted the importance of service providers having a knowledge of the varied backgrounds and cultures service users may be coming from as, for example, one practitioner respondent noted Asian women from traditional backgrounds may not acknowledge marital rape as sexual violence (Hester et al., 2012).

More evidence in relation to ensuring services are inclusive for all victim-survivors is included in Section 6.3.

5.3 Implications for commissioning support services

Based on the available evidence, commissioners should consider:

1. **Improving the inclusiveness of support services.**

   Commissioned services should be able to evidence an ability to engage with victim-survivors whose first language is not English and older victim-survivors. They should also have staff who are trained to understand the intersectional experiences minority victim-survivors face.

2. **Commissioning a range of support services, which meet victim-survivors needs.**

   Commissioned services should publish information on what happens when someone discloses to them, what information they will need to provide and the level of confidentiality and anonymity of the service. Victim-survivors should also have the option access support solely via the phone if they wish.

3. **Increasing the provision of group support.**

   The benefits of increased provision of group support for victim-survivors should be considered, to allow victim-survivors to connect with others.

4. **Improving public and victim-survivor awareness of sexual violence and support services available to them.**

   There should be improved training and guidance for formal and informal support providers on how they can effectively and sensitively support and point victim-survivors towards formal support. This guidance should be carefully drafted with input from victim-survivors and their informal support networks.

6. Findings: Structural factors

Even if a victim-survivor wants to seek help, they may face structural barriers in relation to the way services are designed and delivered that may make it difficult or even impossible for them to be able to access services. This section of the report explores these structural barriers, with consideration for how these can be overcome to best support victim-survivors. It also explores what victims want and what works at a structural level in supporting them.

6.1 Support services available to adult victim-survivors

Lack of availability of support services as a barrier to accessing support

In order for victim-survivors to be able to access support, there must be appropriate services available to them, however the reviewed evidence highlights that a lack of available services acts as a barrier to some victim-survivor respondents being able to access support in England and Wales, as well as internationally (Anderson & Overby, 2020; Champion et al., 2021; Donne, 2017; Hester & Walker, 2018; McIlwaine, 2019; Magic, 2013; Scott et al., 2015; The Survivors Trust & Rape Crisis England and Wales, 2015; Thiara & Roy, 202). The evidence suggested that gaps in service provision, particularly for male and LGBT victim-survivor respondents, acted as a barrier in being able to access support as it was highlighted that the majority of specialist sexual violence services are primarily for women (McDonald & Tijerino, 2013; Magic, 2013).

Some victim-survivors who took part in research in England and Wales described the availability of support services as a 'postcode lottery', highlighting vast variations in the quality and provision of services, with some victim-survivors noting that support was not available at all in some areas due to lack of funding (Champion et al., 2021). One victim-survivor respondent was told to use a family or friends address to be able to access support in an area where it was available. Others who participated in the research reported that they were told support was not available to them due to the incident being more than 12 months ago or due to having an ongoing criminal justice case.

Even if support services do exist within victim-survivors local area, some victim-survivors who took part in research, including in England and Wales, reported facing long waiting lists to access support (Anderson & Overby, 2020; Champion et al., 2021; Walker et al., 2019). Furthermore, when they did access support, these support services did not always meet their needs, for example, not being offered enough sessions to support them in them in the medium- to long-term beyond initial crisis counselling (Anderson & Overby, 2020; Champion et al., 2021; Donne et al., 2017). One victim-survivor respondent noted that the 45-50-minute sessions were too short to be able to get comfortable going into the traumatic situation (Donne et al., 2017).

Support needs

The literature review identified the types of support victim-survivors want available to them. This was consistent in England and Wales and internationally. These include: helplines, advocacy, therapeutic support, counselling, group support, ad hoc telephone support, practical support (with housing, education, benefits employment and health), ISVAs, assistance navigating the criminal justice system, crisis counselling, legal support (i.e. relating to immigration status), victim compensation, mental health support, peer support and medical treatment (Champion et al., 2021; Donne et al., 2017; Du Mont, MacDonald, White & Turner, 2013; Gagnon et al., 2018; Hester & Walker, 2018; McDonald & Tijerino, 2013; Safelink, 2016; McIlwaine, 2019; The Survivors Trust & Rape Crisis England and Wales, 2015).

It is clear from the existing evidence in England and Wales that victim-survivor respondents report wanting to be able to access a range of support but there is no consistent package of support that victim-survivors want, given they often have distinct needs and needs which may change over time (Hester & Walker, 2018; The Survivors Trust & Rape Crisis, 2015). Research suggests that typically, more intensive emotional support is needed immediately following referral but, once involved with an ISVA or specialist support service, the level of support required tends to stabilise, becoming less frequent during the police investigation (if the victim-survivor chooses to report to the police) but often increasing again as the trial draws closer (Hester & Walker, 2018). Therefore, one of the most important factors victim-survivor respondents reported wanting available from support services is choice (Gagnon et al., 2018; The Survivors Trust &

Rape Crisis, 2015). Some victim-survivor respondents also highlighted that they wanted the support available to them to be able to evidence previously meeting victim-survivors needs in the following ways: increased ability to cope, feeling more in control, feeling safer, increased self-care, more positive coping mechanisms developed, improved relationships, feeling more able to rebuild their life, feeling believed and listened to, feeling supported and having more knowledge about sexual violence. In relation to choice, some victim-survivors also reported wanting a choice of female or male support worker, with some reporting they want support via women-only or men-only referral pathways as this helped them feel safe (The Survivors Trust & Rape Crisis, 2015).

Victim-survivor respondents in England and Wales reported wanting specialist sexual violence support available to them (Champion et al., 2021; Hester & Walker, 2018; The Survivors Trust & Rape Crisis, 2015). Some victim-survivor respondents felt that voluntary specialist services provided a more holistic approach to meeting their needs and urged statutory providers to learn from voluntary sectors approach to providing counselling, help and support (The Survivors Trust & Rape Crisis, 2015). Participants suggested statutory services need to be more ‘person-centred’ and reportedly said they wanted to be able to access services which are well-informed and have a comprehensive understanding of the impact of sexual violence. They felt that specialist services that understand a survivor’s reactions are a normal response to trauma can prevent the use of other medical services. Similar findings were found in research conducted with victim-survivors and support practitioners in England and Wales. It was felt that specialist services were able to effectively support victims due to their detailed knowledge and understanding of the unique impacts of sexual violence, combined with skills within and across specialist services and quick referrals between services (Hester & Walker, 2018). Non-specialist agencies such as statutory mental health services are not considered able to meet victims’ needs in the same way; it is felt they are not able to provide targeted responses and are only able to offer time limited support. It is therefore important that specialist sexual violence support services are available to victim-survivors.

Minoritised female victim-survivors who took part in research in England and Wales also reported needing to be supported by specialist practitioners with understanding, skills and experience in providing intense and wide-ranging support to respond to all their needs

(Thiara & Roy, 2020). Victim-survivors who participated in the research valued that specialist women's services provided them with a space of safety, reassurance and affirmation, where they were supported to speak and "actually hear someone listening" (Thiara & Roy, 2020, p.50), enabling them to break years of enforced silence about sexual violence. They emphasised the importance of providers starting with a gentle approach within long term, holistic support, to enable trust to be built so they could speak without a fear of judgement. In summary, respondents emphasised the need for specialist rather than generic support in helping them to view their coping as a source of strength and to heal and recover. It is important to note, however, that some victim-survivor respondents did feel they also need to be able to access statutory mental health services if they choose to (Scott et al., 2015; The Survivors Trust & Rape Crisis, 2015). For example, it was felt that specialist sexual violence services were not always equipped to deal with the mental issues that some were struggling with and limited in the amount of time they could offer to victims (Scott et al., 2015). Irrespective of whether the support provided is through mental health services or voluntary services, participants highlighted the need for the available services to provide continuity of care and be provided by well-trained empathetic staff who understand the relationship between mental ill health and abuse.

Victim-survivors who participated in research in England and Wales particularly valued the support of ISVAs, with some suggesting all victim-survivors going through the criminal justice process should have access to one (Champion et al., 2021; Hester & Walker, 2018). Most respondents who were allocated an ISVA reported not only valuing the wrap around service they offered but also the close working relationship they developed with them that made them feel genuinely cared for. It was found that ISVAs, with input from specialist sexual violence support, effectively meet these needs by providing victim-focused flexible support, targeting support as and when the victim-survivors needs changed (i.e. increasing counselling when they were feeling depressed and providing emotional and practical support throughout the criminal justice process, empowering them to make their own decisions at their own pace) (Hester & Walker, 2018).

Victim-survivors who participated in research in England and Wales also report wanting the support available to them to be open ended rather than time-limited (Champion et al., 2021; The Survivors Trust & Rape Crisis England and Wales, 2015). Some victim-

survivors who reported having positive experiences of support continued to receive support after their case ended and valued being told they could recontact support as they need it (Champion et al., 2021). Whilst victim-survivor respondents reported value in support providers being able to assist them in navigating the criminal justice process, they highlighted the importance of the support service being independent of the CJS, so they could feel someone is on their side.

6.2 Awareness of and referrals to services

Lack of awareness of and referrals to services as a barrier to accessing support

Even if services are available, victim-survivor respondents in both England and Wales and internationally report not always being aware of them or how to access them (Champion et al., 2021; Chynoweth et al., 2020; Harvey et al., 2014; Holland and Cortina, 2017; Sit & Stermac, 2021; Thiara & Roy, 2020).

Both LGBT individuals who have and have not experienced domestic abuse, stalking and harassment and sexual violence (DASH/SV) in Wales directly said they would not have the knowledge of where to look for LGBT-friendly support following sexual violence (Harvey et al., 2014). It was highlighted that knowledge of LGBT-friendly support services typically spread through the LGBT community predominately through 'word of mouth' therefore LGBT people who are not integrated into the LGBT community (for example, if they were not 'out') would face more challenges in accessing services as they would not be pointed towards services in this way.

A sample of victim-survivors who self-reported as living in poverty in Canada also reported facing distinct barriers in relation to the awareness of and access to support services, as they have limited access to computers and phones to search for information directly, social isolation and a distrust of statutory services who they may otherwise be signposted to support from (Sit & Stermac, 2021).

College aged victim-survivor respondents in the US reported not accessing support as they thought there was a time limitation for accessing support; some felt by the time they had come to terms with the fact they had experienced sexual assault, it was too late to seek support (Holland & Cortina, 2017). It was suggested that educational efforts should

reduce these misperceptions by including more detailed information about sexual assault centres mission and services.

Male refugee victim-survivors who participated in research reported not accessing support as they did not want to access care through women-oriented services, such as women's centres which focused on responding to gender-based violence (Chynoweth et al., 2020). They highlighted that referral routes for male survivors were either insufficient or non-existent due to a lack of awareness of sexual violence affecting males, services not being advertised as available to male survivors and limited staff capacity. The need for awareness raising and outreach with male survivors was highlighted to ensure male victim-survivors were able to be referred onto and access support.

Research conducted in England and Wales with 23 service providers supporting older survivors (aged 60 and over) revealed that a lack of awareness of the existence of support services acted as a barrier to them seeking support (Bows, 2018). All practitioners interviewed felt their organisation had an important role to play in improving awareness. Participants acknowledged that there was insufficient collaboration at a local and national level between age-related organisations such as Age UK, rape crisis centres, sexual assault referral centres (SARCs) and domestic violence organisations. As one participant stated, “we should be going to Age UK so women know we are here, they can get support” (Bows, 2018, p.1081), to ensure older victim-survivors are aware of and therefore can access services. Some participants also highlighted particular challenges in ensuring their services reached minority groups of older victim-survivors, including men and older people from BME groups. All 23 practitioners suggested there should be joint campaigns and joint training (e.g. between rape crisis centres, age-related organisations, the police and adult protection services) to raise awareness and encourage cross-referrals between organisations.

Many victim-survivors who participated in research in England and Wales reported relying on information from GPs about support services, who rarely informed them of specialist women's services, therefore delaying access to vital support (Champion et al., 2021; Thiara & Roy, 2020). For some women it took between 2 and 7 years to access the right support and they reported spending a lot of time caught up in referrals between different agencies and on waiting lists. In research conducted with BME female victim-survivors, it

was found that initially the most accessed services were GPs, women typically presented with depression or anxiety and were either referred onto generic counselling (as opposed to specialist sexual violence support) or medication (Thiara & Roy, 2020). Victim-survivor respondents noted it was difficult to disclose sexual violence to GPs as the GP they saw frequently changed. One victim-survivor also highlighted a dangerous GP response whereby the GP wanted to talk to both the husband and wife together, after the wife disclosed sexual violence, instead of referring the victim-survivor on to a support service. In some instances, respondents reported being given a list of support organisations by statutory services, but it was not always clear which organisations they should contact, leaving them confused and alone. Based on these findings, it is clear there are missed opportunities by statutory services to inform victim-survivors of the support available to them or refer them on to specialist support.

Research conducted in England and Wales suggests that some victim-survivors rely on referrals being made by the police to support services (Thiara & Roy, 2020; Champion et al., 2021). Irrespective of whether a victim-survivor had already sought support or not, it was found that only around half of victim-survivor respondents interviewed in research in England and Wales were given referrals or signposted to external support services by the police upon reporting, leaving victims feeling alone and unsafe. Participants were also not always informed of ISVAs or SARCs; they suggested that more effort should be put in place to explain to victim-survivors what these services are and how to access them. There were also instances where the support they were signposted to was not appropriate. For example, one non-binary participant was signposted towards a service exclusively for male victim-survivors. These acted as key barriers them being able to access relevant and timely support.

Adult victim-survivor support needs in relation to awareness of and referrals to support services

Victim-survivors need to be aware of the support available to them and how to access it. Outreach activities were recommended as one way to improve victim-survivors awareness of and access to vital support (Harvey et al., 2014, Sit & Stermac, 2021). Outreach activities targeting LGBT people in partnership with LGBT community organisations and increased partnership working between D/SV service providers and LGBT organisations

were recommended to reach LGBT victim-survivors (Harvey et al., 2014). One specific recommendation given was for D/SV services to have stalls at events like Pride festivals and other LGBT community events to raise awareness of services. Participants noted that funding constraints on D/SV organisations hinder organisations from being able to actively engage with LGBT communities; whilst they showed sympathy for these constraints, the lack of engagement could be perceived as not being interested in LGBT people's experiences of abuse. To ensure victim-survivors who are not in contact with statutory services are aware of what services are available to them and how to access them, victim-survivors highlighted a need to distribute advertisements in public community spaces, such as health centres and libraries and to make resource lists and referrals available through emergency services (Sit & Stermac, 2021). Victim-survivors who took part in research in Canada, who self-reported as living in poverty, also raised the importance of being reassured by victims who had previously used the services that it is a safe, non-judgemental place.

Another suggestion given to improve victim-survivors' awareness of and access to support services identified within the research is by ensuring that statutory agencies are making timely referrals and signposting to external organisations such as ISVAs (Thiara & Roy, 2020). As victim-survivors frequently initially present at GPs with depression or anxiety, some victim-survivor respondents reported wanting GPs to ask more direct questions about the cause of their depression and anxiety to enable them to disclose the abuse. It has also been suggested that there should be local discussions between statutory agencies, sexual violence specialists and 'by and for' BME ending-VAWG organisations to establish effective structures for multi-agency working and referrals. Victim-survivor respondents in England and Wales also reported wanting GPs, police and others who may receive a first response to be trained so they can ask the right questions and refer the victim-survivor on to specialist sexual violence services (The Survivors Trust & Rape Crisis England and Wales, 2015).

In England and Wales, qualitative data from 6 case study sites and quantitative data from 35 sexual violence projects in England and Wales compared the advantages and limitations of delivering support to victims of sexual violence in different settings (SARCs[13]

[13] SARCs are government-led initiatives.

with ISVAs, voluntary projects with ISVAs, SARCs without ISVAs and voluntary projects without ISVAs) (Robinson & Hudson, 2011). The findings revealed that, although having an ISVA in post raised voluntary agencies abilities to engage with other agencies by attending meetings and making themselves known to partner agencies, service providers working in the voluntary sector struggle to get consistent referrals from the police. This did not appear to be an issue for SARCs, where police are embedded in the model of service delivery. Those working in both SARCs and voluntary projects agreed that multi-agency partnership working is vital in providing effective referral routes. It is important to note, however that the independent nature of voluntary services was highlighted as important for effective delivery of services; this was reflected in the data which showed many more self-referrals were to voluntary projects than SARCs. Both access routes are important, as not all victim-survivors will report to police and therefore have the opportunity to be referred on in this way, however it is clear relationships and referral routes between statutory agencies and support services are essential to make victim-survivors aware of and able to access vital support.

In terms of accessing support, victim-survivors who participated in research in England and Wales report wanting flexible access routes with the option to access support through text, email, in person or via a third person referral (The Survivors Trust & Rape Crisis, 2015). They also highlighted the importance of being able to re-access support as and when needed and ensuring the services are accessible in terms of varied appointment times, clear and known referral pathways and a quick response from service providers. There was agreement among respondents that there is a need for services to work together to ensure information about different types of support was available from various sources.

6.3 Inclusiveness of services

Lack of inclusiveness of services as a barrier to accessing support

Victim-survivors, particularly those from minority backgrounds, who took part in research in England and Wales and internationally report not being able to access support due to fears of being misunderstood, treated insensitively or even turned away, for example, due to their gender, sexual orientation and/or ethnicity (Donne et al., 2017; Gooch, 2011;

Harvey et al., 2014; Hester et al., 2012; Jordan, Mehrotra & Fujikawa., 2020; Love et al., 2017; Thiara, Ng & Roy, 2015; Thiara & Roy, 2020).

Male victim-survivors who took part in research in the US report struggling to find the 'right fit' of professional to support them, understand their specific perspectives, be non-judgemental and make a connection (Donne et al., 2017). One victim-survivor felt they were stereotyped by the support provider and told they were supposed to like sex which made them very uncomfortable, reporting it "messed me up" (Donne et al., 2017, p.9).

The lack of inclusiveness of services was also highlighted to be a barrier in accessing support for LGBT+ victim-survivors who participated in research in England and Wales and internationally (Gooch, 2011; Harvey et al., 2014; Jordan et al., 2020; Love et al., 2017). In a survey with LGBT BME victim-survivors it was found 50 per cent reported not accessing support for fear of discrimination due to their sexual orientation or gender identity and 25 per cent reported accessing support but were discriminated against (Love et al., 2017). LGBT individuals highlighted their experience of assumed heterosexuality in services they access in their daily lives, such as GPs, and they therefore expect DASH/SV services would be the same, which acts as a barrier to accessing support (Harvey et al., 2014). They also highlighted difficulties for trans individuals to access often gender binary services. Although service providers who participated in the research noted they are flexible in ensuring people receive support irrespective of their gender, online participants highlighted that concern around being identified as a binary gender would or previously had put them off seeking help. They also reported that service providers did not fully understand how different forms of violence and abuse can overlap for LGBT individuals, for example, services for sexual abuse are often separate to services for hate crime, despite the two overlapping, meaning they are not confident in being provided a joined-up service. A participant also described their experience of a provider making them feel as though the abuse was a result of their sexual orientation. Trans domestic violence and sexual violence advocacy or rape crisis providers who took part in research in the US reported that victim-survivors are deterred from accessing support as the services are seen as trans-exclusionary (Jordan et al., 2020). Participants reported this exclusion was either explicit by not allowing trans victim-survivors to use their services or implicit through the use of gender language and imagery in provider materials and/or websites which

reinforces perceptions that services are solely for cisgender individuals. They noted that where it is not explicit that trans victim survivors will be welcomed, survivors may be deterred from accessing services for fear of being judged, rejected or scrutinised. Participants highlighted that trans men and other trans people who do not identify as women are often left with few or no options as both gender specific service models aimed at women and the services offered to cisgender men may feel unsafe or not relevant to their specific needs. It was also highlighted within research that trans victim-survivors may face stereotypes, such as that a trans person must have deceived the perpetrator about their gender or that trans women should be able to physical defend themselves from sexual violence, leading to victims being treated like perpetrators (Gooch, 2011). Such stereotypes make it harder for trans victim-survivors to get the help they deserve.

Research suggests that BME victim-survivors in England and Wales may also face barriers related to the lack of inclusiveness of services (Love et al., 2017; Thiara, Ng and Roy, 2015; Thiara & Roy, 2020). It was highlighted that experiences of racism from other service professionals meant many victim-survivors may avoid mainstream support services. Racism from support workers, including stereotypes about religion, sexuality and/or language issues, have been echoed in previous research (Hester et al., 2012). Minoritised victim-survivors who took part in research in England and Wales and had accessed SARCs did not have a positive experience (Thiara & Roy, 2020). They reported SARCs having a clear lack of intersectional understanding.[14] Participants reported receiving unsupportive questioning by service providers which made them doubt themselves in a wider societal context of racism. They also reported an overemphasis of providers questioning the victim's behaviour. Similar findings were reported in relation to mental health teams that women interacted with; participants reported a lack of understanding of their needs and experiencing discriminatory and racist responses from providers, such as not believing they were a genuine victim. This further deterred respondents from accessing future support. Examples of agencies having a limited understanding of their experiences included agencies automatically looking for patterns of forced marriage, female genital mutilation and honour-based violence creating short term

[14] Intersectional understanding refers to a theoretical framework for understanding power and oppression which emerged through the socio-historical and political struggles of black resistance and liberation movements, originally conceptualised through critical, black, feminist activism (The Combahee River Collective, 1979).

and siloed practice responses. Minoritised survivors' contexts were also reported to be not addressed well using standardised risk assessment tools where the risk assessment focused on what was happening opposed to why it was happening, why they couldn't report it and the type of violence experienced. It was found that specialist women's services often had to intervene when there were missed opportunities for intervention because of racialised assumptions held by other service providers about the types of abuse minoritised women experience.

Adult victim-survivors need for inclusive services

It is commonly highlighted by victim-survivors who participate in research in both England and Wales and internationally that services need to be inclusive and/or have specific services tailored specifically to their needs (Donne et al., 2017; Gooch, 2011; Harvey et al., 2014; Hester et al., 2012; Jordan et al., 2020; Love et al., 2017; Thiara, Ng & Roy, 2015; Thiara & Roy, 2020).

Several recommendations were identified in the literature to ensure inclusive support services are available to LGBT+ victim-survivors. Firstly, victim-survivor respondents highlighted that there is a need for the professional supporting them to be close to their own identity, such as being LGBT+ or lesbian, gay, bisexual, transgender, queer plus (LGBTQ+) -friendly (Donne et al., 2017; Harvey et al., 2014). It was also found that LGBT victim-survivor respondents want to be supported by a provider who understands LGBT-specific experiences of abuse without assuming the abuse was directly related to the sexual orientation or gender identity, given that a lack of knowledge from providers around same sex relationships, diversity in sexual orientations and gender reassignment are also seen as barriers to help-seeking (Harvey et al., 2014). It was also noted that there is a lack of knowledge within LGBT organisations around domestic abuse, stalking and harassment and sexual violence (DASH/SV), which is an issue given LGBT victim-survivors will often seek support with LGBT organisations first (Harvey et al., 2014). The participants reported wanting sexual violence services to be more inclusive for LGBT individuals. To do so, it was suggested that service providers should be encouraged to promote their services more inclusively, for example, through showing LGBT people in their promotional materials or using the LGBT rainbow flag, undertaking outreach activities targeting LGBT people, and increasing partnership working between domestic and sexual violence service

providers and LGBT organisations. One specific suggestion was to investigate on a small scale the value of providing specialist LGBT workers in sexual violence services and/or specialist D/SV workers in LGBT services. It was suggested that LGBT organisations, whom victim-survivors may initially disclose to, could contact a range of sexual violence support organisations directly to determine how trans-inclusive they are, build up a database that includes relevant trans inclusive organisations and their capacity and trans-friendly individuals in larger support organisations to enable effective referrals to be made (Gooch, 2011). The need to use the client's preferred name, gender and pronouns was also highlighted and to model this for other organisations when making referrals; however, it was noted not to say the client is on the trans spectrum unless they have given explicit permission to do so. Finally, as found in other research, the research recommended that clear confidentiality policies are necessary to give victim-survivors reassurance that they will not be outed while using the services and policies should be adhered to throughout the organisation, with training provided to put this into practice.

To increase inclusivity of services for BME victim-survivors, it was suggested that partnerships between sexual violence support organisations and specialist BME services would be valuable and that all service professionals should be aware of the intersections of identities and experiences their service users may have (Love et al., 2017). Ten out of twenty (50%) LGBT survivors who took part in a survey in Brighton, England, deemed it "quite" or "very important" to disclose to a person of the same sexual orientation and 82 per cent of all respondents considered it "very" or "quite important" to disclose the person of the same gender identity. All cisgender participants and 75 per cent of trans respondents considered this important. Participants also reported wanting to be supported by a service provider who intimately understood their experiences and professionals felt that LGBT and BME service users are more likely to access services if they can see LGBT and BME volunteers or staff members. Survivors were clear that they wanted to be supported by someone of their community. It is important to note that these findings are from a survey with a small sample size (20) and need to be tested in a larger scale survey in England and Wales. There was no evidence within the present study that BME survivors would find BME led support services more useful, however there was a low response rate of BME survivors within this study.

In contrast, in other research in England and Wales victim-survivor respondents highlighted a clear need for BME 'by and for' led services (Thiara & Roy, 2020). Victim-survivor who took part in the research reported wanting earlier access to BME workers who understand the intersections of their lives and the totality of their experiences based on the intersecting impacts of racism and sexism, without having to explain. Furthermore, they valued the lack of assumptions made based on their ethnicity/religion, especially when they had previously had negative experiences with statutory agencies. It was highlighted that once they received support and advocacy from BME organisations and specialist women's services they felt liberated. As clearly outlined by one victim-survivor:

> "There needs to be both so women have a choice as we are always going to see women that will want to access a specialist BME service and therefore I think it's really important that BME women's services are able to respond to sexual violence. But I also think that there will always be women that will prefer to access mainstream services as well so they should get an appropriate response within a mainstream [sexual violence] service" (Thiara, Roy & Ng, 2015, p.26).

It is therefore recommended that the development of both 'by and for' BME ending-VAWG sector and Rape Crisis services should be supported to ensure that victims' support provision can meet the needs of BME victim-survivors (Thiara & Roy, 2020). There should be training and development so that specialised sexual violence support services can strengthen their current responses to minority victim-survivors. There should also be training and development for 'by and for' BME ending-VAWG organisations to strengthen their practice in relation to supporting victim-survivors of sexual violence. Specialised women's services and 'by and for' services must collaborate to ensure cross partnership working and effective referrals are in place.

Support services also need to be inclusive for victim-survivors with learning disabilities. In England and Wales, an evaluation of SAFE Link's specialist learning disability ISVA service, which provides information, advice, support and guidance tailored to the needs of victim-survivors with learning disabilities, was conducted (Safelink, 2016). One of the key findings was that the service was effective in raising awareness of rape and sexual abuse within the learning disability community and giving survivors a clear message that their experience matters. The learning disability ISVA reported adapting to the needs of victim-

survivors by working with social service learning disability teams to access training and seek advice, developing easy read resources suitable for people with learning disabilities to help them stay engaged and speaking with intermediaries around how to adapt materials into understandable formats. The learning disability ISVA reported when they first do an appointment, they take a rucksack with different communication tools, including leaflets and sensory tools to ensure victim-survivors are relaxed. The evaluation drew on case notes, an interview with the learning disability ISVA, interviews with victim-survivors and a survey with services. Victim-survivor feedback and outcomes (difference scores between before and after support) were positive, with victim-survivors reporting improved health and wellbeing and increased safety. They also reported feeling more informed about services available to them and kept up-to-date and had improved experience of the CJS following learning disability ISVA support. Victim-survivors who took part in the research reported that the learning disability ISVA improved their health and wellbeing by providing emotional support, highlighting that the service adapted to meet their needs in ways statutory services such as GPs did not, such as communicating in clear, easy language and being able to guide the pace of work. Victim-survivor respondents also valued that the learning disability ISVA provided clear, consistent communication adapted to their needs such as speaking face-to-face rather than communicating in writing. It was reported that prior to the learning disability ISVA service, victim-survivors with learning disabilities would often disengage from the SafeLink service as staff did not have the time or resource to meet their learning needs and learning disability services did not have enough skill or expertise to deal with sexual violence. Findings from the survey sent out to services who had worked with the learning disability ISVA service were also positive. All respondents agreed that the service: empowered clients to make informed choices following their experience of SV; led to their clients engaging coping and recovering from their SV experience; led to better coordination of care; raised awareness of SV among people with learning disabilities; met unmet need for people with learning disabilities; improved information sharing between agencies/services; and worked well with their partnership with their service. Overall, the findings suggest that, to reach victim-survivors with learning disabilities effectively, services must change their ways of working to meet the needs of victim-survivors with learning disabilities, rather than expecting these victim-survivors to fit into existing models of service. More research is needed to ensure changes to services to meet these needs are informed by victim-survivors themselves.

6.4 Physical location of services

Physical location of services as a barrier to accessing support

The reviewed evidence suggests practical barriers relating to the physical location of the office may mean victim-survivors are not always able to access support in England and Wales and internationally (Anderson & Overby, 2020; Champion et al., 2021). Some victim-survivors who took part in research in the US highlighted that immediately following the assault, it is often difficult to get to the support service, either due to a lack of access to transport or being under the influence rendering them unable to drive (Anderson & Overby, 2020). It was also highlighted that most services are located out of residential areas meaning victim-survivors have to have money to get the bus or drive there, which is not always possible.[15] Many participants also noted that they could not seek help due to work schedules and/or working in jobs which would not give them the time off to access support. One participant also highlighted an additional barrier which came with being a single mother being a lack of childcare. They highlighted that they couldn't go to services during the evening as they would have to take their children. Location of formal support was also raised as a barrier by some victim-survivors who took part in interviews in England and Wales, with some noting that they were often made to travel long distances for support sessions and even attend meetings in the area where the incident happened, which they described as "triggering" (Champion et al., 2021). Some participants described support workers and services as lacking flexibility, with one respondent reporting, "I was very lucky that my work is flexible as the ISVA wanted very fixed times" (Champion et al., 2021, p65).

Victim-survivor support needs in relation to the physical location of support

While engaging with survivors at the organisation's location may be the most feasible for support providers, it may not be reaching enough victim-survivors. It has therefore been recommended that services such as support groups and counselling should be offered throughout the community during different times to reach survivors unable to travel or take time off work (Anderson & Overby, 2020). If offering this type of support is not viable for support services, engaging trained volunteers to provide transport or childcare may help survivors overcome these barriers. Another suggestion made included offering crisis and

[15] It is important to note that as this finding was from a US study in 2020, it may not be applicable to the current provision of support in England and Wales, as many support organisations in England and Wales are available in cities and provide the option to access formal support remotely.

individual counselling online or over the phone, something which has increased during the pandemic. Victim-survivors who took part in qualitative research in England and Wales also raised the need to be supported in a safe, calm and non-clinical environment (The Survivors Trust & Rape Crisis, 2015). They also report wanting services to be available to them close to home and a variety of appointment times available to them, over the phone, email or in person.

6.5 Criminal justice process

Assumption that you need to report to the police to receive support as a barrier to accessing support

A lack of knowledge of the criminal justice process and misconceptions around having to report to the police in order to access support can act as a barrier to victim-survivors seeking support in both England and Wales and internationally (Zinzow et al., 2021). However, this perception is not accurate in England and Wales as support providers offer victim-survivors valuable support irrespective of whether they want to report to the police or not.

A previous review of international literature on the barriers sexual violence victim-survivors face to formal help-seeking found that many do not seek support as they believe it would result in a report being made to the police (Zinzow et al., 2021). Various reasons given in qualitative research by participants for not wanting to report to the police include concerns around not being believed, intrusive evidence collection, not wanting court involvement, fear of the perpetrator or community, harms to their career and/or public embarrassment.

What support adult victim-survivors want from support services in relation to the criminal justice process

The evidence suggests that victim-survivors want to be able to access support irrespective of whether they report to the police or not and they need to be aware that they are entitled to support irrespective of whether they do so. Recommendations include making victim-survivors aware of this such as via improved educational efforts to help target myths and provide information about what resources are available for victim-survivors. This information should be clear that victim-survivors can access support, irrespective of whether they wish to report to the police or not.

If victim-survivors do decide to report to the police, research from England and Wales found respondents want support to include help navigating the criminal justice process (Champion et al., 2021; Hester and Walker, 2018; The Survivors Trust & Rape Crisis, 2015). Victim-survivors who took part in research found impartial conversations with support services around the positives and negatives of reporting their case to the police valuable. Qualitative interviews conducted with twenty-one victim-survivors in Hong Kong found that health care providers requested the victims to inform the police without taking their emotions into consideration (Hung, 2013). This made victim-survivors feel “uneasy and distressed” (p.6). This suggests whilst support providers may have a role to play in helping victim-survivors to report to the police if they wish, they should not take this choice away from victim-survivors.

Other positive experiences in relation to support at the beginning of the criminal justice process in England and Wales included making anonymous enquires to the police on the behalf of victims and supporting them through the initial report process (whether this be a call or police visit). Other victim-survivors reported that the support of an ISVA was beneficial at each stage of their criminal justice process, including building their knowledge and understanding of the criminal justice process (Hester and Walker, 2018). Initially, they helped to allay their fears around the criminal justice process, dispel myths about the process and reassure them of the positive role criminal justice agencies can have. Participants reported that this enabled victim-survivors to make an informed decision around whether to report to the police or not. Once victim-survivors had reported to the police, ISVAs were viewed as effective in keeping victim-survivors engaged in the criminal justice process by keeping a clear line of communication between criminal justice agencies and the victim-survivors around what was happening with their case, as well as assisting with external influences such as employment and health which may otherwise lead to them disengaging with the criminal justice process. Finally, ISVAs also helped with referring on to other services where appropriate. The six victim-survivors who reached court reported that they would not have been confident enough to go to court if it wasn’t for their ISVA. They reported ISVAs were particularly effective in reducing anxiety by reassuring victim-survivors that the outcome of their case was determined by evidence rather than whether the victim was believed; a common misconception victim-survivors had about the criminal justice process. As clearly highlighted in round-table discussions held with victim-survivors

in England and Wales, victim-survivor respondents want support without agenda. They do not want support which forces them to pursue criminal justice action, however if they do decide they want to report to the police, they want to be supported by the service in doing so (The Survivors Trust & Rape Crisis, 2015).

Effectiveness of support in relation to the criminal justice process

The literature review found qualitative and quantitative evidence, in both England and Wales, Scotland and internationally, for the positive impact of support on increased engagement with the criminal justice process (Brooks & Burman, 2016; Molina & Poppleton, 2020; Patterson & Tringali, 2015; Walker et al., 2021).

Research was conducted in Scotland to evaluate the 'Support to Report' (S2R) 24-hour advocacy support programme, launched to assist rape victims at the initial stage of reporting to the police (Brooks & Burman, 2016). S2R, based in Glasgow Rape Crisis Centre, aimed to improve the support available to victims of rape, improve their experience of the CJS and reduce victim attrition in rape cases. Findings were drawn from 9 qualitative interviews conducted with adult victim-survivors who used the service. All respondents described advocacy support as having a positive impact on their ability to engage in and remained engaged with the criminal justice process. They described the non-judgemental support they experienced from the advocacy worker as essential to enabling them to report to the police and that the provision of information, support and advice after the police statement enabled them to continue with the process. The advocacy support also meant that the information provided was clearer, for example, the advocate explained to the victim that the police were misinterpreting what she was saying as she was so hysterical the information was not being communicated clearly. The advocates knowledge of the criminal justice process was valued and at the early stages of the criminal justice process this boosted victim-survivors confidence and helped them make informed decisions around whether to pursue a criminal justice case. The more friendly and comfortable environment of the rape crisis centre where the advocates were based also provided a better environment for giving a police statement and recalling details of the rape. Victim-survivor respondents also highlighted the importance of the advocate being independent of the CJS. They valued that the independent advocacy worker would follow up information with the police, as they felt nervous about making

contact themselves, and also helped them to fill out compensation forms. The independent nature of the advocate allowed them to challenge police practice where appropriate. They also valued that the advocate was a consistent point of contact, especially given they came into contact with many other individuals throughout the often lengthy criminal justice process. Furthermore, information and support advocates gave around how to cope with the process, as opposed to simply giving information about the process, was considered to be a unique feature of advocacy support that went beyond the support received from other agencies. They reported valuing assistance in understanding their reactions to the process (and the rape itself), having support when unable to disclose to or rely on informal support networks and support overcoming feelings of self-blame. Overall, the findings highlight the importance of advocacy that is independent of statutory and criminal justice agencies being available. However, this doesn't mitigate the need for specialisation in the criminal justice response to rape.

Qualitative interviews were conducted with 23 victim advocates in the USA to better understand their role in fostering victim engagement (Patterson & Tringali, 2015). The victim advocates felt that utilising an empowering approach with victims by providing emotional support, assessing and addressing immediate needs and withholding blame and judgement made the victims they worked with feel they have someone on their side. They noted that this encouraged engagement with the CJS by addressing a common barrier to victim engagement – a fear of not being believed. The advocates reported playing an important role in encouraging victim engagement by addressing victim safety concerns and dispelling rape myths, which moves victim anger away from themselves. They also reported that practical support such as offering to accompany the victim to police interviews also encouraged the victims to report the crime to the police.

Large scale quantitative and content analysis of 585 reports of rape recorded within two police force areas in England explored the role of victim support services in victim engagement and the impact on case outcomes (Walker et al., 2021). The research found over a third of complaints were referred to or receiving support from specialist sexual violence support services. Compared to those not receiving support, incidents reported by the victims who were receiving support were significantly more likely to be deemed a crime. They were also nearly twice as likely to result in a conviction, 42 per cent less likely

to result in ‘no further action’ and 49 per cent less likely to withdraw from the CJS. This indicates that not only did the involvement of victim support services at the investigation stage improve victim engagement with the CJS, but also had a significant impact on outcomes.

Similar findings were found in research conducted in England and Wales by the Victims Commissioners Office (VCO) (Molina & Poppleton, 2020). It was found that that 10 per cent of survivors who received help from either an ISVA or other support services decided to take no further action/withdrew their support, compared to 20 per cent of those who did not receive such support. Where victim-survivors did receive support of an ISVA at court, they praised them, noting they helped them to understand what was happening and organising their statements. In contrast, a participant who did not have ISVA support offered to them found the court process unclear and reported that, “the whole experience was daunting” (Molina & Poppleton, 2020, p.49). Victim-survivors report wanting better access to ISVAs and support services.

6.6 Implications for commissioning support services

Based on the available evidence, commissioners should consider:

1. Improving referral pathways.

Commissioners should work to improve referrals by identifying and sharing referral pathways and working with statutory agencies, such as GPs, to ensure clear referral processes are in place for victim-survivors to access sexual violence support.

2. Commissioning a range of support services, which meet victim-survivors needs.

This could include commissioning services which allow victim-survivors to be supported by someone close to their own identity and/or who understands their intersectional experiences, ensuring support services being commissioned make it clear they are inclusive through promotional materials and non-gender specific language and commissioning some ‘by and for’ services, particularly for ethnic minority and trans victim-survivors.

Commissioners should commission services which are able to evidence previously meeting victim-survivors needs in the following ways: increased ability to cope, feeling

more in control, feeling safer, increased self-care, more positive coping mechanisms developed, improved relationships, feeling more able to rebuild their life, feeling believed and listened to, feeling supported and having more knowledge about sexual violence.

Commissioned services should provide flexible access routes to support (with the option to access support through text, email, in person). There should be increased outreach activities to ensure victim-survivors are aware of support services.

7. Conclusion

The themes identified in this literature review addressed each of the three key research questions by outlining:

- Barriers victim-survivors face in accessing support;
- What support victim-survivors want, and
- Limited evidence in relation to the effectiveness of support.

The literature review has focused on existing direct research with either adult victim-survivors or victim support providers published in English language between 2011 and 2021. After examining for relevance and quality, the search produced 54 publications for inclusion in this review. Summaries of the included publications are included in Appendix B.

The literature review has revealed the multiple barriers victim-survivors may face, firstly when deciding whether to seek support, and secondly when attempting to access support. It demonstrated that victim-survivors can face multiple intersecting barriers at the individual, social, cultural and structural level. Many of these barriers were found to be universal to all victim-survivors who participated in the identified research (i.e. shame, self-blame, lack of availability and awareness of services), however there were also some key distinct barriers victim-survivor respondents may face depending on their age, gender, sexual orientation, ethnicity and background. The literature review also identified recommendations, directly from victim-survivors, support providers and other academics, on ways to overcome these barriers. Some of these recommendations should be trialled on small samples before adopting them nationally, as they are currently not evaluated for effectiveness.

The studies reviewed also revealed clear themes around what victim-survivors want from support, both in terms of the type of support they want and how this is effective. However, it is also clear from the literature review that each victim-survivors journey to resilience is unique and can change over time, and key to supporting victim-survivors is ensuring flexibility and choice. Therefore, it is important that commissioners continue to fund a range of types of formal support, from multiple support providers.

There was limited evidence identified in relation to the effectiveness of support. The limited evidence base primarily focused on the effectiveness of psychological interventions in improving mental health outcomes, for which there is promising evidence. There was also some limited evidence to suggest that support – particularly advocacy – is effective at improving victim engagement with the CJS. The lack of evidence in relation to the effectiveness of other forms of support (i.e. helplines, peer support) is likely due to methodological challenges and costs associated with conducting evaluations of support provided by community-based support services.

It is important to highlight both the evidence gaps and limitations to this literature review. The majority of the identified literature, particularly in relation to the barrier's victim-survivors face and what support they want, relied on small scale qualitative studies or surveys where the samples were self-selecting and therefore not generalisable to all victim-survivors. It also relied on the available evidence that was identified through the current search terms; whilst mitigations were put in place to ensure the literature review was as comprehensive as possible (through quality assurance and peer review) we cannot guarantee all evidence was included. There was also a distinct lack of research identified on the needs of disabled victim-survivors and very limited evidence in relation to older victim-survivors, meaning their voices are not represented in this review.

To address these evidence gaps and limitations, the evidence base developed within the survey will be utilised to gain further quantitative insight into the most common barriers and facilitators sexual violence victim-survivors in England and Wales face. The survey will also be used to understand victim-survivors' priorities in terms of what is wanted or needed from support, exploring if and how this varies by respondent demographics. Finally, the survey will provide an opportunity to consider what outcomes victim-survivors want from accessing support. This will help to determine if services that are being funded meet victim-survivors' needs in the future via ongoing monitoring. The findings from the third strand of the research programme, qualitative interview and focus groups, will fill the evidence gaps in relation to disabled victim-survivors. However, more evidence is needed in relation to older victim-survivors, whom may also be hard to engage with an online survey. Targeted recruitment will be conducted to attempt to increase engagement with these victim-survivors specifically.

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[16] The reference list includes all sources which have been cited within the report. This includes the 54 articles included within the literature review, which directly address the research questions, plus additional sources which were not included within the review but cited for background information (for example, the Rape Review was referenced in the background section of this report but was not included as one of the relevant papers for this literature review, as it did not address the research questions within this review).

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Appendix A
Summary of included evidence

A summary of the 54 research reports included within the literature review are provided below. Sources referenced in the background section of the report, or used to provide definitions only, were not included directly within the review and are therefore not summarised within this Appendix. Only findings relevant to the research questions are included in the summaries.

Anderson and Overby (2020)

In the US, qualitative semi-structured interviews were conducted with 19 female, trans- and non-binary survivors of sexual violence, who also worked as domestic violence or sexual assault practitioners, to understand the unique perspective of survivors who are also service providers. The interview transcripts were coded based on grounded theory. The findings identified several barriers that sexual violence victim-survivors face in accessing support services, grouped into structural barriers and internalised barriers. Structural barriers identified included difficulties accessing a physical support location due to transportation issues (not being able to drive to the location), perceived cost of services meaning that the victim-survivors felt they could not afford support, a perceived lack of availability of services able to provide ongoing support, and an inability to take time off work to receive support. Internalised barriers included shame, worry and fear experienced by victim-survivors – for example, many participants had highlighted the stigma that occurs for survivors when seeking support. Other internalised barriers reported included perception of service not being able to help, trauma, shock and delay in reaching out and not considering their experience as 'serious enough' to warrant seeking support due to comparing it to others' experiences. The researchers obtained informed consent and participants were given resources regarding support organisations following participation.

Australian Institute of Family Studies (2017)

The Australian Institute of Family Studies conducted a rapid evidence review of existing Australian literature on sexual violence prevention, education, crisis and long-term support, police training and capacity building. Of relevance to this literature review, their rapid

evidence assessment highlighted that since the 1970s, there has been a focus on providing victim-survivors support that is specific to the physical, emotional and sexual trauma experienced following sexual violence. This includes a need for access to appropriate forensic examination and immediate crisis counselling, as well as longer term support. The literature review also highlighted the need for services to offer trauma-informed care to victims of sexual violence that must consider the sensitivities and vulnerabilities of victim-survivors. An important factor in developing trauma-informed services is creating an emotionally and physically safe environment where trauma is asked about and acknowledged as well as providing confidential services. It was recommended that this should be delivered through ongoing cross-sector training to ensure services available to victims are trauma informed.

Bows (2018)

In England, interviews were conducted with 23 practitioners supporting older survivors (aged 60 and over) to understand the barriers to providing support to sexual violence victim-survivors. The findings revealed that the emotional challenges that victim-survivors face when accessing support such as shame, fear, anxiety, and self-blame are magnified for some older survivors. It was also found that ageist attitudes and beliefs may be barriers that older people face in accessing support. This is based on the rape myth that rape is linked to sexual desire, together with perceptions of older people as sexually undesirable. These myths made it difficult for victim-survivors to acknowledge their experience. Another barrier identified was a lack of awareness of the existence of support services. All practitioners interviewed felt their organisation had an important role to play in improving awareness. Participants acknowledged that there was insufficient collaboration at a local and national level between age-related organisations such as Age UK, rape crisis centres, SARCs and domestic violence organisations. All 23 practitioners suggested that there should be joint campaigns and joint training, for example, between rape crisis centres, age-related organisations, the police and adult protection services, to raise awareness and encourage cross-referrals between organisations. This may encourage older victim-survivors to engage with services. Ethical approval was granted by Durham University and researchers obtained informed consent from participants at the outset.

Brooks and Burman (2016)

Research was conducted in Scotland to evaluate the Support to Report (S2R) 24-hour advocacy support programme. This programme was launched to assist rape victims at the initial stage of reporting to the police. Findings were drawn from nine qualitative interviews conducted with adult victim-survivors who used the service. They described the non-judgemental support they had experienced from the advocacy worker as essential to enabling them to report to the police and that the provision of information, support and advice after the police statement had enabled them to continue with the process. The advocacy support made the information provided to them clearer and their knowledge of the criminal justice process was valued. At the early stage in the criminal justice process, this increased victim-survivors' confidence and helped them make informed decisions around whether to pursue a criminal justice case. The more friendly and comfortable environment of the rape crisis centre where the advocates were based also provided a better environment for recalling details of the rape and giving a statement. The independent nature of the advocate allowed them to challenge police practices, where appropriate. Victim-survivors also valued that the advocate was a consistent point of contact. Furthermore, information and support advocates gave around how to cope with the process was considered to be unique compared to support received from other agencies. Researchers gained informed consent from all participants.

Burrowes (2013)

Portsmouth Abuse and Rape Counselling Service provided group support for women on their waiting list to support them as they awaited one-to-one therapy. Session content included learning about the brain and trauma, awareness raising and exercises such as learning about the window of tolerance. Qualitative interviews with women who attended found that the group context of the support was effective, with victim-survivors reporting that being in a group reduced their sense of being alone and provided them with ongoing social support. They learned new ways of understanding their behaviour in the group therapy, which gave them hope that they could eventually do something about it. They also reported being able to see things from a different perspective and therefore felt better prepared for starting their one-to-one therapy. The material covered in the programme was also considered effective; it helped them to understand their reactions better and gave them tools to deal with anxiety. Overall, the findings suggest group psychotherapy is

beneficial for victim-survivors who are awaiting one-to-one treatment. Researchers chose the approach they believed was ethical in terms of ensuring their voices were heard. Potential participants were screened to ascertain whether taking part could potentially cause them harm and they checked with participants to ensure that they had support available following participation.

Champion et al. (2021)

Across England and Wales, 26 qualitative interviews were conducted with adult rape survivors. Victim-survivors reported valuing being able to share their experiences in a safe and non-judgemental space, having their experiences and feelings heard and validated, receiving advocacy around the criminal justice process, receiving support and advice from knowledgeable, well-trained practitioners, receiving person-centred support that focused on their overall wellbeing as opposed to the incident and receiving support that was independent of the criminal justice system. Several barriers to accessing support were highlighted by victim-survivors, including long waiting lists, time-limited support and availability of services being a 'postcode lottery'. Victim-survivors also highlighted negative experiences about practitioners' attitudes, including coming across as disinterested, a lack of understanding around trauma recovery, minimising language, and a lack of diversity amongst support providers. When victim-survivors were asked for recommendations to improve support, they highlighted a need for better training of staff, the need for victim-survivors to be offered a choice of psychotherapy/counselling, ensuring survivors are offered specialist as opposed to generic victim support services, the provision of better legal counsel and spreading wider awareness of the type of support which is available to victim-survivors. Informed consent was obtained at the outset, and participants were reassured of anonymity.

Chynoweth et al (2020)

Researchers conducted 55 semi-structured focus group discussions with 310 refugees, 148 interviews with aid workers and human rights experts and observed service delivery points to gain insight into the barriers that male sexual violence survivors face in accessing services. Through thematic analysis, eleven key barriers were identified. Barriers included restrictions to accessing legal protection, legislative barriers such as the criminalisation of same-sex sexual relations, few designated entry points, poor or non-existent referral

system, lack of community awareness raising and engagement, limited staff capacity, negative provider attitudes and practices, social stigma, limited knowledge (at the individual level), self-stigma and low formal help-seeking behaviours. Ethics approval was obtained from the University of New South Wales and the Kenya Medical Research Institute. The Global Advisory Committee was set up to provide ethical guidance and an additional ethics review was carried out by a university in Italy. National reference groups were set up to review various elements of the project (including providing ethical oversight). The method of data collection (focus groups) was chosen as they were deemed to be the most ethical.

Covers et al (2021)

In the Netherlands, a randomised controlled trial was conducted to assess the effectiveness of early intervention of EMDR therapy. Fifty-seven victim-survivors of rape were randomly allocated to receive either two sessions of EMDR therapy or treatment-as-usual (which included ‘watchful waiting’ whereby two telephone contacts of approx. 30 mins with a sexual assault centre practitioner who provided psychoeducation, active listening and well-informed advice) between 14 and 28 days after the incident. Psychological symptoms were assessed pre- and post-treatment and these symptoms were compared between the two conditions. The findings revealed that EMDR was no more effective than watchful waiting in reducing PTSD, general psychopathology, depression, sexual dysfunction and feelings of guilt and shame. EMDR was found to be more effective at reducing anxiety and disassociate symptoms, however this effect was not maintained over time. The findings therefore conclude that early intervention of EMDR therapy in victims of rape is no more effective than watchful waiting. However, it did provide evidence that EMDR is as effective a treatment-as-usual and is a safe option of treatment of rape victim-survivors. Ethical approval was obtained from the Medical Ethical Committee of University of Utrecht and registered in the Dutch Trial Register. Informed consent was obtained, and potential participants were excluded if they were deemed to be especially vulnerable.

Donne (2017)

Qualitative interviews and focus groups were conducted with 32 men in the US to better understand how males, both straight and gay as well as cisgender and transgender,

conceptualise, understand, and seek help related to sexual violence. Some participants highlighted that they initially struggled to acknowledge what they had experienced was sexual violence. Two participants highlighted that gender and masculinity norms may act as barriers to accessing support, as there is an expectation for them to be strong and unemotional. They noted that there is a societal stigma around men not being able to be raped and those that are, are considered ‘weak’. Another barrier some participants reported was the psychological impact of sexual violence; some reported they did not want to discuss the traumatic event or think about it and therefore did not want to seek support. Other barriers reported included cost, insurance and scheduling issues making it impractical to access support, alongside struggling to find the right fit of practitioner to support them. They wanted to be supported by someone who could understand their perspective and support them in a non-judgemental way, with one black transgender participant reporting "I try to find someone who is as close to my identity as possible" (p.8). Participants gave informed consent and were provided with information regarding support organisations and resources to access following participation.

Du Mont (2013)

In Canada, information was collected from 29 sexual assault treatment centres relating to 38 male clients (aged 12 and over). Time to presentation, client socio-demographic, assailant characteristics, assault characteristics, physical health consequences and service delivery and utilisation were all examined. The findings revealed that 86 per cent of clients used five or more services, most commonly relating to health care such as crisis counselling, treatment of injuries and referral for follow-up care for counselling. The high uptake of services highlights the importance of providing male victim-survivors with access to a comprehensive range of psychological, medical and forensic support options, and of referrals to other community services for ongoing support. Approval was received from all participating sites.

Fehler-Cabral et al (2011)

In the US, 20 qualitative interviews were conducted with rape victim-survivors to understand their experiences with forensic nurse examiners of a Midwestern Sexual Assault Nurse Examiner (SANE) programme. Participants reported mixed experiences with SANE nurses, which highlight what they do and do not want from support providers.

Positive experiences included SANEs providing survivors with care and compassion, clear explanations and choices. In contrast, some victim-survivors experienced cold and distant practitioners and were hurt when they were not provided with clear explanations and choices. This highlights the need for forensic support to be clearly communicated to victim-survivors, giving them choice throughout the process around how, if, and when they want to continue with the examination, provided by a nurse who can display care and compassion. Although ethics were not mentioned explicitly, researchers took steps to ensure victim-survivors' safety and wellbeing, including asking them the safest mode to contact them and ensuring interviews were conducted by a researcher trained in building rapport and increasing victims' comfort.

Gagnon et al (2018)

In the US, as part of a longitudinal study, 224 ethnically diverse adult (aged 18-62) female victim-survivors were asked to provide recommendations for how victim services could best support survivors of sexual assault at multiple points in time. Ninety-one per cent of participants offered specific recommendations. These included ensuring availability of a female provider, improving communication with survivors and both within and between service providers, helping them to obtain resources, making them feel believed and not blamed, a better understanding of trauma-related responses, demonstrating greater understanding and compassion and implementing better training on working effectively with victim-survivors. Participants had given informed consent and the study was approved by a university Institutional Review Board.

Garry and Munro (2020)

In 2020, the Rape and Sexual Violence Project (RSVP) in England and Wales published an initial report on the impact of their adult counselling service for survivors. RSVP provides person-centred, trauma-informed support to victim-survivors. Victim-survivors completed an initial survey on their wellbeing at an assessment session and then counsellors completed wellbeing surveys with them at weeks 1, 8, 16 and 23 of receiving support. There were nine measures used to assess victim-survivor wellbeing: increased confidence, better able to cope, feeling hopeful, more able to make decisions, feeling listened to, feeling safe, ability to trust, more sociable and improved relationships. For three of the measures – improved confidence, ability to cope and decision making –

considerably more than 50 per cent of clients reported positive outcomes. Figures for increased sociability and improved relationship and other measures were slightly lower, but still showed an increase. As highlighted within the report, this is likely due to the need for victim-survivors to be supported in improving their own confidence and coping before they are ready to look outwardly towards social relationships. This suggests that person centred adult counselling was effective in the medium-term at improving victim-survivor self-reported wellbeing. However, it is not possible to compare to outcomes should victim-survivors not have received this counselling.

Gooch (2011)

In 2011, Galop, a London-based LGBT anti-abuse charity, published a toolkit for organisations to become a trans-positive organisation. The toolkit was based on trans individuals' experiences of accessing services explored within focus groups and discussions with LGBT organisations around the challenges that they face. In relation to sexual violence, it was highlighted that trans victim-survivors struggle to find support after an incident; it was reported that they are sometimes excluded from support services because of their gender history or are unable to access help such as rape crisis centres. They may also face stereotypes, such as that a trans person must have deceived the perpetrator about their gender or that trans women should be able to physically defend themselves from sexual violence, leading to victims being treated like perpetrators. It was suggested that LGBT organisations could help victim-survivors who may disclose to them by building up a database of trans inclusive organisations and their capacity and trans friendly individuals in larger support organisations to enable effective referrals to be made. The need to use the client's preferred name, gender and pronouns was also highlighted. Finally, the research recommended that clear confidentiality policies are necessary to give victim-survivors reassurance that they will not be outed while using the services.

Harvey et al (2014)

The Welsh Government conducted an evidence review and primary research on the barriers faced by LGBT individuals in accessing DASH/SV services. Participants highlighted that LGBT victim-survivors may not seek support as they do not view their experience as abuse because DASH/SV tend to be discussed as issues that affect heterosexual, cisgender people. Other barriers included self-blame, not knowing where to

look for LGBT-friendly support and fear of violence from others if they sought help. At a structural and cultural level, LGBT participants highlighted their experience of assumed heterosexuality in services that they access in their daily lives, such as GPs and they therefore assume DASH/SV services would be the same. Participants also highlighted difficulties for trans individuals in accessing often gender-binary services, issues around inadequate staff diversity, knowledge and skills, and experiences of support providers blaming their abuse on their sexual orientation. It was recommended that staff receive formal training in collaboration with the LGBT and DASH/SV sectors. Ethical approval was obtained from NatCen's Research Ethics Committee. Each page of the online portal included telephone numbers and links to support for respondents.

Hester et al (2012)

Research in England was conducted with domestic and sexual violence support service providers and service users to better understand the support needs of male, LGBT and male BME victims of domestic and sexual violence. The research included qualitative interviews, an anonymous online survey, support service data and focus groups. Male victims of sexual violence typically spoke positively about the counselling and support they received from specialist sexual violence services. Generally, respondents felt that victim-survivors should have a choice of the gender of the practitioner supporting them. Respondents who experienced sexual violence were concerned they would experience homophobia when they contacted statutory and specialist support services and that support providers would not understand their experiences. Transgender respondents felt that there was a gap in service provision for them, given that specialist women's sexual violence services primarily support biological women and that other non-specialist sexual violence services focus on wider health issues, emotional support and information linked to trans-issues rather than being able to deal with sexual violence. Male BME respondents also highlighted a gap in service provision. Ethical approval was obtained from the NHS.

Hester and Walker (2018)

Qualitative interviews conducted with 15 rape victim-survivors highlighted that victim-survivors have unique journeys to and through support. Some participants who were referred to GPs for counselling support due to the mental health impacts of the sexual violence noted that they preferred specialist sexual violence services for support as sexual

violence is discussed directly. One participant who was referred to GPs was told that they couldn't deal with them and did not refer them on to support services, thereby leaving the victim-survivor without support for some time. Another participant who was referred by a GP to an NHS psychologist, then referred on to an ISVA, welcomed the flexible combination of psychological support provided by the NHS and specialist support provided by the ISVA. They reported that it helped to address their changing needs over time. For example, the psychologist was able to help with their depression and found that the ISVA was particularly valuable in helping them in a non-therapeutic way to acknowledge and articulate their experience in a safe and neutral place. It was deemed important that the ISVA invested time early on when accessing support to help the victim acknowledge the abuse and understand their emotions, so that they could identify each victim-survivor's individual needs and facilitate access to relevant services for them to recover.
Ethical approval was obtained from University of Bristol and all participants gave informed consent.

Holland and Cortina (2017)

A mixed method approach was utilised in the US using data from 284 women who experienced sexual assault in college to explore why survivors did not use three campus support services. Common barriers highlighted included not knowing that support was available, not knowing how to access it and/or whether it was confidential. Some participants also thought that there was a time limit for accessing support. It was suggested that education could reduce these misperceptions by including more detailed information about sexual assault centres' mission and services. Victim-survivors also experienced internalised barriers such as embarrassment and self-blame. It was also found that victim-survivors did not always access support services as they often minimised the sexual violence they had experienced. They believed the instances were not severe enough to seek support and/or didn't realise until a while later that it was bad. The authors confirmed that they had followed ethical conduct and principles but limited detail was provided.

Holland et al (2021)

Research conducted in the US with a college sample of sexual assault survivors found that 80 per cent (32 out of 40) of interviewees discussed the minimisation of the severity of the

sexual assault they experienced as a reason for not seeking formal help. Examples of this included participants reporting that they did not go to a counselling centre because they had compared what they experienced to what they considered to be an assault which would be ‘serious enough’ to use support services. One participant raised that they never felt their life was in danger during the assault and therefore felt it could have been worse. There was also found to be a social acceptance of ‘less serious’ sexual assault (less serious being those that aren’t forcible penetration) which contributed to the minimisation of other types of sexual violence. One suggestion given by the researchers was to ensure that institutions’ policies and practices are clear that all sexual assaults are taken seriously to make victim-survivors feel that they can use support resources. Procedures were approved by the Institutional Review Board.

Hung (2013)

Qualitative interviews were conducted in Hong Kong with 21 victim-survivors who had reported sexual violence to the police. Key issues were identified for participants when they engaged with the healthcare system. These included negative attitudes of staff towards the victim-survivor. For example, some reported that healthcare providers had tried to make them report what happened to the police, without taking into consideration their emotions. This made victim-survivors feel “uneasy and distressed” (p.6). It was noted that participants gave their consent to be interviewed and during the interviews counsellors were available to provide any necessary support.

Hutschemaekers et al (2019)

Qualitative interviews conducted with 12 female victim-survivors in the Netherlands revealed that in the short-term after the assault, all victim-survivors reported experiencing feelings of self-blame. The victim-survivors benefited from feeling listened to without judgement. Victim-survivors also highlighted that informal support networks played an important role in helping them to look for professional care and, once accessing formal support, it was important that those supporting victim-survivors acknowledged emotions such as shame as normal following assault so that the victim-survivor could feel reassured they were “not abnormal or even going crazy” (p.6). Victim-survivors highlighted that they were disappointed when service providers did not acknowledge their fear, sadness and anger. Others spoke of positive experiences whereby professionals had positively

responded to their nonverbal signs of panic and despair, for example, by interrupting the forensic medical examination. Ethical permission was obtained from Radbound University Medical Ethics Committee. Potential participants were excluded if they were deemed to be especially vulnerable and participants provided informed consent and were guaranteed privacy.

Jordan et al (2020)

Ten qualitative interviews were conducted in the US with transgender individuals working in domestic and sexual violence advocacy organisations. Participants drew on their experiences providing advocacy for trans survivors and some also speaking from their own past experiences of experiencing sexual violence. The findings suggest that there remain inequalities in services for trans victim-survivors. Many reported that DA and SV advocacy organisations within their area explicitly excluded trans victim-survivors. Discrimination described was both explicit through being turned away from services and through discriminatory practices, such as services agreeing to support the victim-survivor on a tacit agreement to not discuss their experiences as a trans individual. Furthermore, gender specific programme models, including the language and imagery used by services, act as a barrier to them being inclusive to trans individuals by reinforcing the idea that services are for cisgender individuals. Researchers selected a methodology appropriate for the research, noting, “we approached practitioner-based research as particularly appropriate to a study of advocacy, honouring the history of community workers at the forefront of theorising on domestic and sexual violence and its interventions” (p.536).

Kirkner et al (2021)

In the US, researchers analysed open ended survey responses from 1,863 victim-survivors and interviewed 45 informal support dyads, survivors and support providers, to identify recommendations for responding to sexual violence victim-survivors. Victim-survivors’ advice for other survivors included the importance of talking to others about their trauma and seeking support from someone with sexual violence training. Victim-survivors recommended that support providers engage in supportive listening without giving pity. They also highlighted the need for support providers to emphasise that the sexual violence is not the victim’s fault and recommended support providers counter rape myths when a victim discloses. Victim-survivors also highlighted that youth in their communities

specifically should be educated about the dangers of sexual violence. It was reported that victim-survivors want to be able to relate to the person supporting them, with one participant highlighting, "I feel like it's easier if you have at least someone that looks like you on campus to feel like okay this happens to not just me" (p.1018). The research team ensured confidentiality between the victim-survivors and support providers were maintained and steps were taken to ensure this confidentiality was not broken. A feminist framework was used in interviews to ensure a safe and supportive environment. All interviews were conducted in compliance with the university's Institutional Review Board.

Linquist et al (2016)

A survey conducted with college sexual assault victim-survivors in the US explored the sexual assault disclosure experiences of historically black college or university students. The survey reported that only 14 per cent (*N*=24 out of 151) of physically forced sexual assault victim-survivors and 8 per cent (*N*=15 out of 136) of incapacitated sexual assault victim-survivors disclosed the assault to a victim-survivors crisis or healthcare centre. Forty-seven per cent of physically forced sexual assault victims and 41 per cent of incapacitated sexual assault victim-survivors who did not report, reported not doing so because the assault was 'not serious enough'. This further confirms that minimisation of sexual assault acts as a key barrier to accessing formal support in young adults. More education around what sexual violence is, particularly highlighting that any form experienced is serious, would help both victim-survivors and peers to acknowledge what sexual violence is. Further education would also help to stop minimising sexual violence, therefore overcoming these barriers to accessing support. Ethical approval was obtained from the Institutional Review Board of RTI (a non-profit research organisation) and the authors confirmed that the research met ethical guidelines and legal requirements.

Littleton et al (2016)

In the US, 87 college women with PTSD as a result of rape were randomly allocated to receive an interactive, online therapist facilitated cognitive behaviour programme (From Survivor to Thriver programme) or a psycho-educational self-help website. The findings revealed that both programmes led to reductions in interview-assessed PTSD post-treatment and at three months follow-up. Victim-survivors also reported decreased depressive and anxiety symptoms post-treatment. Follow-up analysis revealed that the

From Survivor to Thriver programme was more effective for individuals who had higher pre-treatment PTSD, whereas the psycho-educational self-help website was more effective for individuals with lower pre-treatment PTSD. Ethical approval was obtained from institutional review boards at participating universities and community colleges. Participants provided informed consent.

Long and Ullman (2013)

In qualitative research conducted in the US with nine Black female victim-survivors, several women described adopting the persona of the 'strong Black woman' and sought to cope with their victimisation without formal support. One participant noted that they didn't seek mental health support following victimisation because they didn't think they had a problem, based on the assumption that she was not the type of person who would need therapy. Others reported not seeking help for their mental health due to previous negative experiences with mental health professionals. Respondents completing the postal survey were sent a list of referral services once the completed survey was received. A resource pack was given to interview participants, emotional well-being was checked with participants at the end of the interview and participants were given pseudonyms.

Love et al (2017)

In England, a survey with 20 professionals (6 follow up interviews) and 15 victim-survivors was conducted to understand the barriers faced by LGBT BME victim-survivors accessing support services. It was found that 50 per cent of victim-survivors who responded to the survey (*N*=15) reported not accessing support for fear of discrimination due to their sexual orientation or gender identity while 25 per cent who responded to the survey (*N*=15) who had accessed support, reported being discriminated against. Professional participants highlighted that experiences of racism from other service professionals meant many victim-survivors may avoid mainstream support services. Specific cultural issues were also identified as barriers by participants including language barriers meaning victims are not confident accessing services. Professional participants also highlighted the importance of service providers having a knowledge of the varied backgrounds and cultures that service users may be coming from. Being excluded from services was cited as a concern for some survivors, particularly trans survivors. Professional participants were in agreement that services have a duty to work at inclusivity and accessibility and that links between services

are invaluable for doing so. For example, it was suggested that partnerships between sexual violence support organisations and specialist BME services would be valuable and that all service professionals should be aware of the intersections of identities and experiences that their service users may have. Ethical approval was obtained from the NHS Social Care Research Ethics Committee. Participants were given an information sheet and informed consent was given. Following the interview, participants were signposted to support services and organisations.

Magic (2013)

Research was conducted in Newham, England with 45 LGBT respondents and 37 professionals from LGBT as well as mainstream organisations representing a range of services specialising in counselling, wellbeing, sexual health, DV, SV, hate crime, disability, sex work and forced marriage. The findings revealed gaps in service provision for LGBT victim-survivors that acted as a barrier to accessing support. Respondents highlighted that specialist women's domestic or sexual violence services, such as rape crisis centres, design and provide services primarily for women, which means that there are less services available for gay men and trans persons, including trans women. It was suggested that there should be increased collaboration and shared learning between domestic abuse and sexual violence services to improve service provision and delivery for LGBT victim-survivors.

Miller et al (2015)

In research conducted in the US, 164 female sexual assault survivors receiving forensic examinations were randomised to receive either standard care or a brief video-based intervention after their forensic medical examination. The video provided psychoeducation on reactions to sexual assault, modelling of coping strategies, targeting avoidance and strategies to improve mood. The participants completed mental health assessments 2 weeks and 2 months after the examination. The findings revealed that women who received the psychoeducational video had fewer symptoms of anxiety at the follow-up assessments. The findings therefore support the use of the video intervention to support victim-survivors who receive a forensic examination. However, the sample size was relatively small and there was a high dropout rate.

McDonald and Tijerino (2013)

In Canada, interviews were conducted with 59 male victim-survivors who had accessed two centres that provide specific services to male survivors. The findings revealed that many victim-survivors experienced feelings of shame and self-blame following sexual violence. They valued the support that they were provided, with many stating that this was their only source of support to cope with the trauma they were experiencing. They valued having a safe place to talk about the abuse and receive information regarding the criminal justice system. Many victim-survivors highlighted the need for more male-specific support services available to male victim-survivors across the country which take into consideration males' experiences. Informed consent was obtained and follow-up counselling was provided to participants if they requested it.

McIlwaine (2019)

Research consisting of a survey with 50 migrant women and qualitative interviews with a total of 11 migrant women and 10 representatives supporting them was conducted in London to understand their experiences of violence against women and girls (VAWG), as well as support received. Almost two-thirds of the victim-survivors who responded to the survey felt that they would not get support for the gender-based violence they had experienced due to their immigration status. Sixty-two per cent of those surveyed stated that the perpetrator had threatened deportation if they did disclose the abuse. Findings revealed that specialist VAWG support was valuable in supporting migrant victim-survivors; they were effective in advocating for women with local authorities and social services, especially explaining honour-based violence, and they played a valuable role in providing non-judgemental support and safety. Migrant respondents who were supported by a specialist VAWG organisation noted how the support enabled them to feel accepted, learn what their rights were and regain their voice. In terms of the support these respondents wanted, 76 per cent of the women surveyed reported needing support for mental health problems, 60 per cent needed support in the form of housing and benefits advice and 82 per cent identified immigration advice as a major support need. In terms of commissioning, it was suggested by the researchers that there should be funding for specialist VAWG frontline services led 'by and for' migrant and BME women and ring-fenced funding for specialist women's organisations.

Molina and Poppleton (2020)

In a self-selecting survey conducted with 491 survivors of rape in England and Wales, it was found that 10 per cent of survivors who received help from either an ISVA or other support services decided to take no further action/withdrew their support, compared to 20 per cent of those who did not receive such support. Where victim-survivors did receive support of an ISVA at court, they praised them, noting they helped them to understand what was happening and organising their statements. In contrast, a participant who did not have ISVA support offered to them found the court process unclear and daunting. Victim-survivors report wanting better access to ISVAs and support services. The researchers provided details of support organisations and other support services to participants and they asked permission to share quotes in the report.

Nixon et al (2016)

In Australia, 47 victim-survivors with acute stress disorder were randomly allocated to receive either cognitive processing therapy (CPT, *N*=25) or treatment-as-usual from a community sexual assault centre (*N*=22). Those in the CPT condition received six 90-minute sessions which included introducing cognitive restructuring techniques and introducing victim-survivors to alternative ways of thinking. The treatment-as-usual condition received a range of psychoeducation, supportive counselling, mindfulness and discussion of thoughts and feelings. Both groups were assessed at pre-treatment, post treatment, 3, 6 and 12 months follow-up for PTSD, anxiety, depression and substance abuse disorders. The findings revealed that although both treatments led to post-treatment improvements, larger increases were seen on some measures for CPT. For example, assessment of PTSD severity indicated more CPT participants reached good end-state functioning at the 12 months follow-up than those in the treatment-as-usual condition. The findings therefore suggest CPT or rape crisis treatment-as-usual approaches can be effective as an early intervention for victim-survivors. The hospital ethics committee approved the consent forms used and potential participants were screened to confirm whether it was appropriate for them to take part in the research.

Patterson and Tringali (2015)

Qualitative interviews were conducted with 23 forensic nurses and victim advocates in the US to better understand how advocacy may influence victim engagement with the CJS.

None of the participants felt that their primary goal of advocacy was to persuade victims to engage in the CJS, but instead to support the decision made by the victim-survivor around whether or not they wanted to participate in the criminal justice process. The victim advocates felt that utilising an empowering approach with victims by providing emotional support, assessing and addressing immediate needs and withholding blame and judgement made the victims they worked with feel they had someone on their side. They noted that this approach encouraged engagement with the CJS by addressing a common barrier to victim engagement – a fear of not being believed. The advocates reported playing an important role in encouraging victim engagement by addressing victim safety concerns and dispelling rape myths, which moves victim anger away from themselves. They also reported that practical support such as offering to accompany the victim to police interviews also encouraged the victims to report the crime to the police. Research procedures were approved by Wayne State University Institutional Review Board.

Ranjbar et al (2013)

Twenty-seven victim-survivors in England completed an online qualitative survey on their experiences with health professionals following sexual violence. Respondents were recruited through support organisations. They were asked about their experiences in terms of what had facilitated and what had impeded their recovery. The majority of participants reported negative experiences, including health professionals lacking experience in dealing with victim-survivors of sexual violence, persistence of rape myths/stereotypes and disrespectful/inconsiderate treatment of victim-survivors. Support and help from others was deemed critical to their recovery. Only victim-survivors who considered themselves to be recovered were included in the research. Participants were provided with contact details of support organisations on the information page of the survey.

Richardson et al (2015)

A large-scale survey conducted with college students in the US (*N*=2,790) explored self-reports of sexual violence, substance use and help-seeking. Analysis of the survey results revealed that LGBQ individuals were significantly more likely to have reported being a victim-survivor of at least one act of sexual violence (8.1%, *N*=23) than heterosexual individuals (5.4%, *N*=121). LGBQ and heterosexual victim-survivors both had low rates of seeking formal help. The most common reason given by both LGBQ and heterosexual

victim-survivors for not seeking formal help was that it wasn't 'serious enough'. Additional reasons given by all victim-survivors for not seeking formal support included feeling it was partially their fault (self-blame) (e.g. due to drinking), feeling ashamed, thinking they wouldn't be believed and not wanting people to find out. It is recommended that there should be improved education around the significance of any act of sexual violence, no matter the victim's sexual orientation or gender – particularly when alcohol is involved – to enhance engagement with formal support. Furthermore, as the research found that victims most frequently turn to informal support such as a friend following sexual violence, resources should be made available on how to help a friend and identifying signs of distress. Ethical approval was obtained from the institutions' ethics board. Respondents were made aware of their rights and following survey completion they were provided with details of support services.

Robinson and Hudson (2011)

In England and Wales, information from interviews and visits in six case study sites was analysed to compare the advantages and limitations of delivering support to victims of sexual violence in different settings (SARCS with ISVAs, voluntary projects with ISVAs, SARCs without ISVAs and voluntary projects without ISVAs). The findings revealed that although having an ISVA in post raised voluntary agencies' abilities to engage with other agencies by attending meetings and making themselves known to partner agencies, service providers working in the voluntary sector struggle to get consistent referrals from the police. This did not appear to be an issue for SARCs. Those working in both SARCs and voluntary projects agreed that multi-agency partnership working is vital in providing effective referral routes. It is important to note, however, that the independent nature of voluntary services was highlighted as important for effective delivery of services. This was demonstrated in the data which showed many more self-referrals were made to voluntary projects than to SARCs. Both access routes are important as not all victim-survivors will report to police and therefore be referred on, however, it is clear that relationships and referral routes between statutory agencies and support services are essential to make victim-survivors aware of and able to access vital support. Ethics were not mentioned explicitly, but data was drawn from a larger study looking at how ISVA services were implemented in SARCs where ethical principles were considered.

Rothbaum et al (2013)

Promising evidence has been found in the US with the use of a modified prolonged exposure (PE) treatment delivered to women (*N*=28) presenting at an emergency department within 3 days of a sexual assault. Compared to a control group who did not receive treatment, those who received modified PE (including breathing relaxation techniques, self-care strategies, attention to cognitions and repeated exposure to trauma narrative to allow for fear extinction) reported significantly less PTSD four weeks post-treatment. Participants provided written informed consent to participate in the study and completed an initial assessment to determine eligibility. The hospital research oversight committee and university IRB approved this research.

Rymer and Canessa-Pollard (2015)

Mixed-methods research conducted in England with a total of 48 trans victim-survivors explored the barriers they faced in accessing support and what their ideal service would look like. The findings revealed that shame and guilt often stop trans victim-survivors from seeking support. Participants also reported that they were fearful that their experience of sexual violence would be viewed by providers as a result of their gender identity and that they would therefore not be believed, or even blamed, for the violence they had experienced. Forty per cent of the 48 victims who took part in the research reported not accessing services due to a fear of being discriminated against because of their gender identity and a further 20 per cent reported being unaware of services available to them. Other barriers highlighted by participants included fear of being outed while using a support service, a lack of understanding from service providers around the complexities of sexual violence and gender identity and mistrust towards services due to past negative experiences of accessing services. Most respondents (83% of the 48 victim-survivors) noted that they would not feel comfortable accessing services that are gender-binary; they wanted services which see gender as a continuum. They also reported wanting support providers to understand the struggles commonly faced by trans and non-binary survivors and wanted service providers asking them what language they wanted to use to refer to their body. Ethical approval was obtained from the Social Care Research Ethics Committee.

Safelink (2016)

In England and Wales, an evaluation of SAFE Link's specialist learning disability (LD) ISVA service, which provides information, advice, support and guidance tailored to the needs of victim-survivors with learning disabilities, was conducted. The evaluation involved measuring self-reported 'cope and recover' outcomes with victims who received support from the LD ISVA before and after support, client interviews and a survey with 15 services about what they thought about the ISVA role. One of the key findings was that the service was effective in raising awareness of rape and sexual abuse within the learning disability community. The LD ISVA reported adapting to the needs of victim-survivors by working with social service teams to access training and seek advice, developing easy read resources and speaking with intermediaries around how to adapt materials into understandable formats. The LD ISVA reported when they first do an appointment, they take a rucksack with different communication tools, including leaflets and sensory tools, to ensure victim-survivors are relaxed. Victim-survivor feedback and outcomes (difference in scores before and after support) were positive, with victim-survivors reporting improved health and wellbeing and increased safety. They also reported feeling more informed about services available to them, about being kept up-to-date and an improved experience of the CJS following LD ISVA support. All respondents agreed that the service empowered clients to make informed choices following their experience of SV and led to their clients engaging, coping and recovering from their SV experience, better coordination of care, raised awareness of SV among people with learning disabilities, better meet unmet need, improved information sharing between agencies/services and worked well with their partnership with their service. More research is needed to ensure these changes are informed by victim-survivors themselves.

Scriver et al. (2013)

This study looked at quantitative (anonymised) data from Rape Crisis Network Ireland's (RCNI) database which includes data from most of the Rape Crisis Centres (RCCs) in the Republic of Ireland. Data analysed was for all of those using RCNI for counselling and/or support in 2011. This study was particularly interested in those aged 55 or older, which was 6 per cent (*N*=115) of the 2,036 clients. Over half of the older women victim-survivors were accessing support related to sexual violence experienced when they were a child while one-third were accessing support for sexual violence experienced as an adult.

A further 13 per cent were accessing support for sexual violence experienced both as a child and as an adult. Almost two-thirds of the older women had referred themselves, while just over one-third had been referred by someone else. In addition to the quantitative data, two case studies were also included in the research, which illustrated the experience of two women who engaged with rape crisis centres. The case studies showed that the participants were not aware of the support services available to them (or that what had happened to them could be dealt with as the incident(s) had not happened recently). The researchers identified this as a potential barrier to older women accessing support. The researchers also suggested that disability may be a barrier to accessing support for older women in terms of being able to physically access the building, having a disability that may not be catered for (i.e., a deaf victim-survivor who needs sign-language to communicate, or someone who needs support to attend the centre, but does not want to disclose why they are attending to their carer). Therefore, special measures may be required to allow older women to access support services. There may also be an issue with older women not being aware that their experience would be classified as sexual violence (this may be particularly true in cases of intimate partner violence). Informed consent was gained from the case study participants. Trained RCC counsellors interviewed participants and remained available should the participants have required any additional support.

Scott et al., (2015)

Twenty-one in-depth interviews were conducted in England with mental health service users who had experienced domestic and sexual violence to understand their experiences of support services. The findings revealed that interviewees were worried about the current nature of mental health services for survivors; they experienced a reduction in time and input from mental health professionals and high thresholds for being able to access the mental health support they needed. For some, the only support available to them was that provided by specialist sexual violence voluntary services such as RCCs. Whilst this support was viewed positively, it was noted that they were not always equipped to deal with the severe mental health issues that some victim-survivors were struggling with and limited in the amount of time they could offer to victims. Participants therefore highlighted a need for specialist voluntary sector support to be available to them, as well as access to mental health services. Irrespective of whether the support provided is through mental health services or voluntary sector services, participants highlighted the need for the

available services to provide continuity of care and be provided by well-trained empathetic staff who understand the relationship between mental ill health and abuse. The availability of crisis services and group and peer support being available for both male and female survivors was also deemed necessary.

Schwaz et al (2019)

Twenty-one adult female victim-survivors at a non-profit agency in the US completed 8 sessions of EMDR, pre- and post-assessments and an in-person interview to assess the effectiveness of EMDR for women who experienced trauma due to sexual or domestic violence. Analysis of the pre- and post-assessment data revealed a statistically significant improvement in levels of depression, anxiety, PTSD and overall wellbeing symptoms after completing EMDR. Qualitative interviews confirmed these findings, with participants reporting that engaging in EMDR enhanced the therapeutic process, decreased depression and increased confidence and hope. The findings support the use of EDMR as a treatment for victim-survivors of sexual violence. Participants were assured that access to treatment would not be affected by whether they took part in this research and were also told that they could withdraw at any point.

Sit and Stermac (2021)

Qualitative interviews were conducted with 15 female victim-survivors living in poverty in Canada who had accessed support services following sexual violence. Analysis of the interviews revealed three key themes around which participants' recommendations were centred. Firstly, increased accessibility of information. One participant described an initial delay in help-seeking as they had a lack of knowledge around whether what they had experienced was sexual assault. Improved training for formal support providers was another recommendation made. For the majority of participants who accessed community-based support, they reported one of the most valuable factors in their recovery was being able to share their experiences of both sexual assault, poverty and other forms of violence within women's support groups, such as those offered at RCCs. They noted that the mutual sharing of experiences was healing, as it had made them aware that sexual assault was a shared experience, rather than individual, and it had helped to destigmatise their experience, alleviating feelings of shame and self-blame. Furthermore, hearing other victim-survivors talk about their experience and journey to recovery gave them hope for

their own. As women began seeing their own experiences as sources of hope for others, they wanted more opportunities for empowerment and therefore engaged in outreach and advocacy work themselves to help others. Ethical approval was obtained from University of Toronto's Office of Research Ethics. Informed consent was obtained from participants and potential participants were screened to remove any especially vulnerable participants.

Tarquinio et al (2012)

In France, researchers aimed to test the effectiveness of early treatment using EMDR in reducing PTSD and psychological distress. Seventeen female victim-survivors of rape were given psychoeducation on the impact of sexual trauma and one session of EMDR between 24 and 72 hours after the rape occurred. The findings revealed a significant improvement in PTSD symptoms post-treatment. However, these positive changes were not significant at 6 months follow-up. The study therefore provides evidence for the effectiveness of EMDR in the short-term, however the evidence is weak given there was no comparison group used in the study and it relies on pre-post group comparisons. Informed consent was obtained from participants.

The Survivors Trust and Rape Crisis (2015)

Research conducted with 50 service providers and 50 victim-survivors (men and women) in England and Wales provided insight into what services survivors need and what good services look like. Participants suggested statutory services need to be more person centred and said they wanted to be able to access services which are well-informed and have a comprehensive understanding of the impact of sexual violence. A key benefit of a specialist service was being able to receive ongoing support such as helpline, advocacy, therapeutic support, group support and ad hoc telephone support from one service rather than having to receive different aspects of support from different agencies, each time reliving the trauma. Victim-survivors highlighted that they wanted the services available to them to be able to evidence previously meeting victim-survivors' needs in the following ways: increased ability to cope, feeling more in control, feeling safer, increased self-care, more positive coping mechanisms developed, improved relationships, feeling more able to rebuild their life, feeling believed and listened to, feeling supported and having more knowledge about sexual violence. The findings also revealed that survivors need a range of services available to them to support their recovery and importantly a choice of which

they want to access. Victim-survivors highlighted wanting a choice of support providers, both statutory and voluntary sector specialist sexual violence services. In relation to accessing support, survivors reported needing flexible access routes with the option to access support through text, email, in person or via a third person referral. They also highlighted the importance of being able to re-access support as and when needed and ensuring the services are accessible in terms of varied appointment times, clear and known referral pathways and a quick response from service providers.

Thiara et al (2015)

In 2015, research was conducted in England and Wales to understand barriers faced by BME female victim-survivors in accessing sexual violence support services. A national mapping survey was administered to existing sexual violence services to understand the support offered and barriers in responding to sexual violence (*N*=38). Ten interviews were also conducted with service providers to understand the key issues for BME victim-survivors and how service responses can be improved. Barriers highlighted by organisations included: a lack of knowledge and awareness about sexual violence and support services and how to access them; lack of specialist BME women's services; fear of not being believed or taken seriously; previous negative experiences of accessing support; lack of awareness and sensitivity by services; language barriers; cultural factors which prevent women from accessing support due to fear of 'family shame' (e.g. confidentiality concerns); denial by some communities/services; and immigration status. Suggestions offered by providers for addressing these barriers included: offer specialist BME women only services locally; promotional work to engage with BME women to make them aware of the services and build trust; remove language barriers by providing interpreters or having staff who speak the language; provide a directory for BME specific services; better partnership working; and clear referral pathways to BME services.

Thiara and Roy (2020)

Interviews were conducted in England and Wales with 36 BME victim-survivors to provide insight into the barriers they face in accessing support and what they want from support. All victim-survivors reported feelings of shame, guilt and humiliation following sexual violence. One participant raised that they did not want to tell anyone as they were "worried that they were going to see me as being irresponsible in some way" (p.20). Addressing

internalisation and self-blame was one of the powerful aspects of the support victim-survivors valued from support specialists. Most victim-survivors in the study who did receive therapeutic support from specialist services preferred one-to-one rather than group support as they were able to address self-blame and talk openly. Their experiences highlighted the importance of specialist rather than general support in allowing them to feel hopeful and build their self-esteem. They reported needing to be supported by a provider who was not going to judge them. This research also found evidence of general services (such as mental health services) and general sexual violence services (such as SARCs) not being inclusive of the needs of minoritised victim-survivors. They reported SARCs having a clear lack of intersectional understanding. Participants reported receiving unsupportive questioning by service providers which made them doubt themselves. They also reported an overemphasis of providers questioning the victim's behaviour. Similar findings were reported in relation to mental health teams that women interacted with; participants reported a lack of understanding of their needs and experiencing discriminatory and racist responses from providers, such as not believing they were a 'genuine victim' as "she doesn't look like something happened to her" (p.44). The research highlighted that over and above the value that victim-survivors placed on specialist women's services, almost all participants discussed the importance of 'seeing themselves' in the services they access. They want to be able to communicate in their own language and relate to others supporting them and within the service. There is a clear need for collaboration between specialist women's services and 'by and for' BME organisations to establish mutually agreed systems of referral and joint working and to learn from each other. Ethical approval was obtained from the University of Warwick Humanities and Social Sciences Research Ethics Committee. Participants gave informed consent.

Vieweger (2019)

Semi structured interviews were conducted in South Africa with 15 female rape victim-survivors, which provided insight into their experiences of rape crisis counselling and what they wanted from support. It was found that victim-survivors valued receiving counselling in a professional safe space where they felt safe and comfortable. They wanted to receive support in a non-judgemental and confidential way that did not further stigmatise them. Victim-survivors emphasised the need to be able to talk and be heard by an empathetic listener who validated their experiences and reported valuing the feminist counselling

model, whereby they were empowered to actively seek answers and solutions themselves. Finally, they noted that being able to participate in a support group enabled them to feel less alone. The findings provide insight into how victim-survivors want to be supported and should be carefully considered by support services. For example, it highlights the need for counselling to be a collaborative process which is guided by the counsellor but led by the survivor to enable empowerment and should be delivered in an environment that feels safe, but professional. Participants gave informed consent and were told they could withdraw at any point. Various data protection procedures were followed, and pseudonyms were assigned to participants. Participants were offered the option of additional counselling from Rape Crisis if they felt they needed it, as well as information regarding further support services available.

Walker et al (2019)

In England, researchers analysed 863 feedback forms of victim-survivors who had attended Saint Mary's SARC for a forensic medical examination between 2014 and 2017. Crisis workers supporting the victim-survivors were the professionals that victim-survivors most frequently rated as being "very satisfied" with, in terms of their communication, sensitivity and information received. Content analysis of the feedback form responses revealed that clients described the staff as caring, sensitive, informative, helpful, kind, supportive, friendly, professional, understanding, reassuring and welcoming. This gives insight into the type of professional that victim-survivors want to receive support from. When asked in the feedback forms how the service could be improved, 34 responses were given. Clients noted issues around better accessibility of the SARC to avoid delays that they had experienced in being able to access the centre. Victim-survivors also made suggestions for improving the SARC environment, such as providing a TV in the waiting room, offering food and drink and car parking and improvements relating to the forensic medical examination such as improved procedures for medical history taking, clearer explanation from the doctor of the examination and availability of sexually transmitted infection (STI) services. The findings highlight the need for victim-survivors to be able to access a service which is delivered by professionals who treat them in a respectful manner, whilst ensuring they are clearly informed and treated in a comfortable environment. Ethical approval was obtained from NHS Research Ethics Committee.

Walker et al (2021)

Large scale quantitative and content analysis of 585 reports of rape recorded within two police force areas in England explored the role of victim support services in victim engagement and the impact on case outcomes. Victim-survivors who did not receive support were significantly less likely to have their incident deemed a crime by the police than those who did receive support. Compared to those who did not receive support, those who did receive support were twice as likely to have their case result in a conviction, 42 per cent less likely to have their case result in 'no further action' and 49 per cent less likely to withdraw from the CJS. Ethics were not mentioned explicitly, although the authors mentioned that the data was anonymised.

Walshe (2020)

In Northern Ireland, 20 victim-survivors of sexual violence were interviewed to understand the factors that affected help seeking for sexual violence by both men and women. The findings revealed that informal support through friends and family affected their decision around whether to seek formal support. Some victim-survivors reported that they did not disclose to informal support sources as they wanted to maintain relationships or social structures, with one participant reporting that they did not report because they worked together. When victim-survivors did disclose to informal networks, some experienced positive responses such as being believed, supported and offered tangible support. In contrast, some victim-survivors were met with disbelief, doubt and even victim blaming when they disclosed to friends and family which led to them believing that if their friends and family didn't believe them then formal support wouldn't either. In some instances, this deterred them from seeking formal support. Participants attributed the often-poor responses to disclosures to a lack of understanding of the impact of sexual violence. Given that informal support responses when positive can encourage engagement with formal support services, there is a clear need for public awareness raising on this topic. Other factors which affected these victim-survivors' decisions whether to seek support included: denial and minimisation of the experience; relationships with the perpetrator creating fear, shock or disbelief; and fear of not being believed. Some were also unaware of what services they could access. When accessing support, participants described a need to be believed and have someone to acknowledge the impact and seriousness of what happened. Ethical approval was obtained from the University of Ulster Research Ethics

Committee and Dublin Rape Crisis Centre consented to the research being conducted with their service users. Measures were put in place to support both participants and researchers due to the potential distress caused by these discussions. Informed consent was obtained from participants and information was provided regarding support organisations following the interviews. Various data security measures were put in place.

Westermarland and Alderson (2013)

In 2013, research was conducted in England and Wales to develop and pilot a tool called 'Taking Back Control', which measures the impact of Rape Crisis counselling on victim-survivors' physical health, mental health and wellbeing. The 15-item tool was developed based on a review of existing tools being used, tools to measure depression, anxiety and wellbeing and interviews with Rape Crisis Centre staff, local funders and commissioners. The 15-item tool measured the extent to which victim-survivors: feel empowered and in control of their life; have flashbacks about what happened; have panic attacks; use alcohol to help them; feel depressed; have thoughts about ending their life; feel well enough to work or study; have a fear or phobia that prevents them from doing everyday tasks; feel responsible for what happened to them; over-eat, under-eat or use food as a means of control; self-harm to help cope with feelings; and use non-prescribed drugs to help them cope. The tool was administered by the victim-survivor's counsellor either at week one or two of receiving support and then every six weeks thereafter. The findings revealed that counselling had the biggest reduction on the extent to which victim-survivors felt empowered and in control of their life; 61 per cent strongly disagreed at the start of counselling compared to 31 per cent when counselling was complete. There was also a large reduction in the extent to which victim-survivors reported having flashbacks and panic attacks. Other measures all saw some degree of positive change. It is important to note that this study provides insight into the outcome measures used to measure impact and provides an initial evidence base into the benefits of Rape Crisis counselling but does not provide a thorough evaluation of the services provided. Ethical approval was obtained from the Ethics Committee of the School of Applied Social Science at Durham University. Informed consent was obtained from participants and they were informed that their relationship with the Rape Crisis centre would not be affected by their participation.

Zinzow et al (2021)

A systematic review of the published international literature on barriers to formal help-seeking following sexual violence was conducted. It is important to note that this review explored help-seeking in relation to reporting the sexual violence to the police and healthcare providers, as well as support services. At the individual level, a lack of acknowledgement of sexual victimisation acts as a key barrier to help-seeking and this can be influenced by the type of assault experienced. At an individual level, personal feelings of stigma, shame or discomfort in discussing sexual violence also relate to decreased likelihood of accessing support services. At the microsystem level, the review found that survivors from the US, Europe and Asia are deterred from seeking formal help due to fear of reprisal from the perpetrator or the community. Victim-survivors may also experience negative reactions such as blame or disbelief when they disclose the sexual violence informally and this acts as another barrier to formal help-seeking. Furthermore, victim-survivors are sometimes put-off from seeking formal help as they believe that they will have to report to the police to ‘prove’ their stories when they do not want to. Finally, a lack of social support was found to be linked to a decreased likelihood of seeking form help. At the mesosystem and exosystem levels, it was found that resource issues act as a key barrier to help-seeking. When they were able to access services, it was felt that the providers lacked the necessary skills to provide support, such as a cultural and linguistic competence, competence related to working with disabled and minority groups or those with multiple needs (i.e. comorbid mental health diagnosis). At the macrosystem levels, gender stereotypes were found to act as a major barrier to formal help-seeking following sexual violence. For example, males who are victimised may fear being labelled as weak and thus conceal the assault and females who are victimised may conceal sexual violence from relatives due to a belief that they are submissive to men, particularly male relatives. The review also found cultural barriers to formal help seeking. For example, in societies where there is a strong emphasis on familial honour and respect, disclosing abuse threatens to bring shame upon the whole family, such as the mother being blamed for not encouraging her daughter to dress modestly and avoid sexual behaviour.

Appendix B
Key search terms used in literature search

Victim (s)/ survivor/ victim-survivor/ complainant/ practitioner/ support provider/ service provider/ service user/ case worker/ voluntary agencies/ counsellors

Rape/ sexual violence/ sexual assault

Support/ help seeking/ supporting/ specialist services/ support services/ voluntary sector/ recommissioning/ statutory services/ generic service/ by and for

Want/ need

Experiences/ views/ explore/ survivor informed/ journey/ access/ contact/ referral/ reasons

Challenge/ barrier/ deter/ facilitate

Effectiveness/ evaluation/ outcome/ randomised control trial/ impact/ reduction/ improvement/ impact / works/ improves/ victim satisfaction/ victim wellbeing / victim trust/ victim engagement/ disengagement/ attrition/ cope/ recover

LGBT/ LGBTQI+/ BME/ Black and minority ethnicity/ transgender/ lesbian/ gay/ male / female / men/ women/ elderly / older / disabled / disability/ protected characteristics/ migrant

Note: Searches made use of keywords in title search, combined with a subject and abstract search.

Appendix C
Products available in EBSCO and ProQuest resources

EBSCO Discovery Service:

This resource contains the following products:

1. **OpenDissertations (ddu)** - Link to resource information: https://www.ebsco.com/products/research-databases/ebsco-open-dissertations

2. **Criminal Justice Abstracts with Full Text** - Link to resource information: https://www.ebsco.com/products/research-databases/criminal-justice-abstracts-full-text

3. **MoJ Library full-text E-Journals Subscriptions**:

   Emerald Journals Listings
   Safer Communities: 2002–
   Therapeutic Communities: 2012–

   Sage Journals
   Crime and Delinquency: 1999–
   Criminal Justice and Behaviour: 1999–
   Criminology and Criminal Justice: 2006
   International Journal of Offender Therapy and Comparative Criminology: 1972–
   Journal of Contemporary Criminal Justice: 1999–
   Journal of Interpersonal Violence: 1999–
   Prison Journal: 1999–
   Probation Journal: 1999–
   Punishment and Society: 1999–
   Sexual Abuse: 1999–
   Trauma, Violence and Abuse: 2000–
   Youth Justice: 2001–
   Youth Violence and Juvenile Justice: 2003–

Science Direct Journal Listings

Aggression and Violent Behaviour: 1999–

Wiley Journals

Criminal Behaviour and Mental Health: 1997–

Criminology: 1970–

Criminology and Public Policy: 2001–

Legal and Criminological Psychology: 1997–

Taylor Francis Journals

Journal of Offender Rehabilitation: 1997–

Women and Criminal Justice: 1997–

4. **MEDLINE:** Link to resource information: https://www.ebsco.com/products/research-databases/medline

5. **Ministry of Justice Library Catalogue:** There is no live status information i.e. availability of collection. This would be at additional cost.

6. **PsycARTICLES:** Link to resource information: https://www.ebsco.com/products/research-databases/psycarticles

7. **Psychology and Behavioural Sciences Collection:** Link to resource information: https://www.ebsco.com/products/research-databases/psychology-behavioral-sciences-collection

8. **PsycINFO:** Link to resource information: https://www.ebsco.com/products/research-databases/psycinfo

9. **Sociology Source Ultimate:** Link to resource information: https://www.ebsco.com/products/research-databases/sociology-source-ultimate

Proquest Search Platform:

1. **Applied Social Sciences Index & Abstracts (ASSIA):** Link to resource information: https://www.proquest.com/products-services/ASSIA-Applied-Social-Sciences-Index-and-Abstracts.html

2. **ECONLIT:** Link to resource information: https://www.proquest.com/products-services/econlit-set-c.html

3. **ERIC**: Link to resource information: https://www.proquest.com/products-services/eric.html

4. **National Criminal Justice Reference Service (NCJRS) Abstracts Database**: Link to resource information: https://www.proquest.com/libraries/academic/databases/ncjrs-set-c.html

5. **PAIS:** Link to resource information: https://www.proquest.com/products-services/pais-set-c.html

6. **PTSD:** Link to resource information: https://www.proquest.com/products-services/pilots-set-c.html

7. **Sociological Abstracts:** Link to resource information: https://www.proquest.com/products-services/socioabs-set-c.html