



Ministry  
of Justice

# Formal support needs of disabled adult victim- survivors of sexual violence

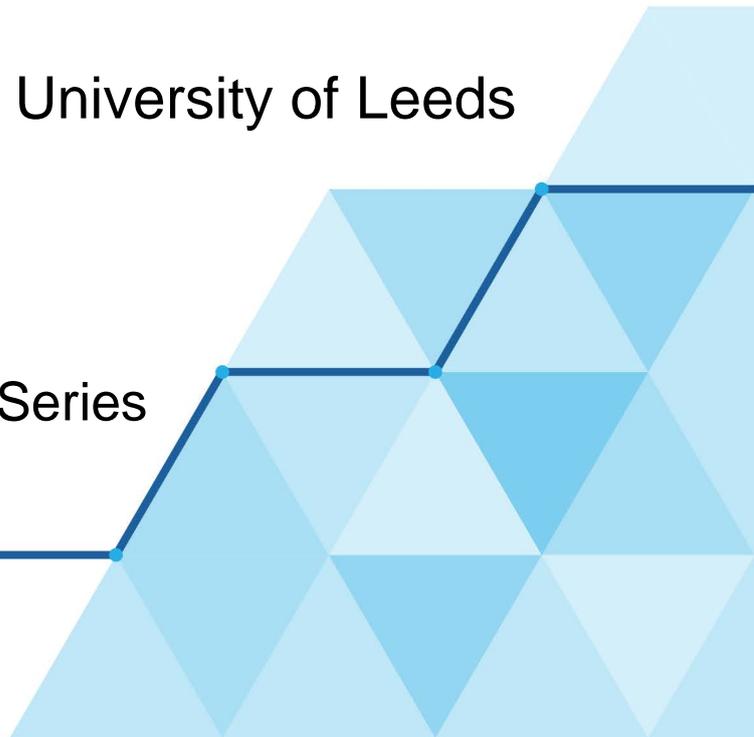
## A qualitative research report

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# List of abbreviations

ACPO- CPS	Association of Chief Police Officers & Crown Prosecution Service
BME	Black and minority ethnic
BSL	British Sign Language
CBT	Cognitive Behavioural Therapy
CCGs	Clinical Commissioning Groups
CJS	Criminal Justice System
CPS	Crown Prosecution Service
CSEW	Crime Survey England and Wales
EMDR	Eye Movement Desensitisation and Reprocessing
ISVA	Independent Sexual Violence Adviser
MoJ	Ministry of Justice
NSE	National Statement of Expectations for commissioning Violence Against Women and Girls services (Home Office, 2022a)
ONS	Office for National Statistics
PCC	Police and Crime Commissioner

PTSD Post-Traumatic Stress Disorder

RNID Royal National Institute for Deaf People

SARC Sexual Assault Referral Centre

# 1. Executive Summary

## 1.1 Research context and methodology

This qualitative research with disabled victim-survivors of sexual violence has been carried out as part of a wider research programme in the context of a public commitment in the Rape Review Action Plan. The aim of this research was to present findings and recommendations that can help to inform recommissioning of the Rape and Sexual Abuse Support Fund to help ensure that it meets the needs of all victim-survivors. To be able to deliver this, the research aimed to explore the following questions:

**Q1:** What do disabled sexual violence victim-survivors want from victim support services?

**Q2:** What do they consider to be effective in helping them **(a)** engage with the criminal justice process and **(b)** cope and recover from the crime?

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**Q3:** How can sexual violence victim support services become more inclusive?

The research has been conducted to a tight timeline with a geographically diverse sample across England and Wales. Thirty semi-structured interviews and two focus groups were conducted with a total of 39 disabled victim-survivors. Disability is defined as by the Equality Act 2010 and the respondents had a range of impairments covered within this definition. Respondents had the option to use creative methods when talking about their experiences and when visualising a fully inclusive victim support service. Most interviews were held remotely. Two interviews and the focus groups were conducted face-to-face.

This research report centre-stages the voices of disabled victim-survivors. The researchers were advised by Ministry of Justice (MoJ) to prioritise the findings which directly relate to the research questions from respondent accounts in writing up this research

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report. The findings and recommendations will be considered alongside all three strands of the research programme conducted by MoJ, which engages in more detail with existing literature and the policy landscape. Overall, the MoJ programme of research highlights the range of policies relating to the rights of disabled victim-survivors that currently exist, whilst this research report evidences that these are not always adhered to.

## **1.2 Findings and key recommendations**

Key findings from this research are presented under five sub-headings, which are presented

chronologically to follow the journey of a victim-survivor accessing services. They include: **(I)**

Pathways into victim support services, **(II)** Enforcing initial needs assessments, **(III)** Preparing for the

arrival of disabled victim-survivors through the design of inclusive services that are accessible to all and **(IV)**

putting the disabled victim-survivor at the centre of

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service design. Solutions in these four areas are best delivered **(V)** by working in partnership with disabled victim-survivors. Each of these groups of findings begins with a sample quote from Chapter 4 in the main report, which illustrates a barrier that contextualises the recommendation. Key findings are associated with a list of key recommendations.

**I. Ensure there are the right pathways into victim support services through effective referrals and liaison with relevant agencies.**

“I remember breaking down in the bathroom after [forensic medical examination]. And then they tried to explain all the different aspects and they hand you this booklet, and the last thing you can do after that is really hear all the things they’re saying or read through a booklet. It’s just so overwhelming.” (Quinn)

Many disabled victim-survivors who participated in this research felt they had been excluded from sexual

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violence support services from the onset, due to not knowing services existed or not trusting that these would be able to support a disabled person. Many never accessed the breadth of services available to sexual violence victim-survivors. There appeared to be limited access to ISVAs<sup>1</sup> for those in health and social care settings. Three respondents who experienced sexual violence by a paid carer reported that the perpetrator continued to work in the care setting where they perpetrated this sexual violence, after these respondents found safety. Their continued presence could pose considerable risks to other users of these settings.

Respondents reported better outcomes when they had been referred to a service, rather than signposted. Signposting merely provides information

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<sup>1</sup> Independent Sexual Violence Advisers (ISVAs) act as a single point of contact who provide impartial information to the victim-survivor. They can provide emotional and practical support (Home Office 2017).

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about service options and relies on the victim-survivor's ability to understand this information and initiate contact. Current policies relating to the right to be signposted exist, including the Association of Chief Police Officers & Crown Prosecution Service (ACPO-CPS 2015) *Protocol* and the *Code of Practice* (MoJ, 2021b) but the experiences of respondents in this research were that these were not consistently implemented. The *Serious Violence Duty* (Home Office, 2022, p.7) asserts that "Serious violence has a devastating impact on lives of victims and families, and instils fear within communities and is extremely costly to society". It places duties on Clinical Commissioning Groups (CCGs) to assure delivery of serious violence prevention strategies.

### **Recommendations:**

- By strengthening liaison work with agencies who are required to deliver the *Code of Practice* (MoJ, 2021b), ACPO-CPS (2015) *Protocol* and

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*Serious Violence Duty* (Home Office, 2022b), victim support services can proactively ensure these agencies are aware of the breadth of services they offer, especially for victim-survivors with additional support needs, thus enabling more consistent referrals.

- Increase the number of specialist ISVAs in health and social care settings.
  - Victim-survivors who come forward from these settings should, where needed, be allocated an ISVA who is trained to support them and has sufficient time allocated to enable multiagency working to maximise outcomes in the criminal justice system (CJS) to enable more known perpetrators to be barred from working in care settings.

## II. Enforce initial needs assessments

“It’s impossible to follow what people are saying unless they actually face me, and I can see their lips moving. And people [...] get completely frustrated at their attempts at trying to communicate with you even though you’ve explained several times all you need to do is face me and talk to me and I’ll be able to follow you pretty much okay.” (Sean)

Disabled victim-survivors who participated in this research wanted to be asked about their access needs by those they approached for help, including the police and victim support services, and for these needs to be met, but their experiences were inconsistent. In line with the *Code of Practice* (MoJ, 2021b) disabled victim-survivors who report to the police should have had an initial Needs Assessment undertaken by the responding officer at the time of initial contact, but this did not always happen

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especially for those whose impairment was not visible. Only one respondent recalled using an intermediary.<sup>2</sup> Several had struggled with communication difficulties that could have been mediated by such support and this resulted in some of the respondent's cases being discontinued. "Police officers have a responsibility to identify that there is a difficulty communicating directly with a witness" (Crown Prosecution Service (CPS), 2021). ISVAs and advocates can play a vital role in advocating for these responsibilities to be met.

### **Recommendations:**

- Sexual violence support services need to ask all victim-survivors about access needs upfront and they need to ensure this information is shared between relevant agencies;

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<sup>2</sup> A Registered Intermediary is a communication specialist who helps vulnerable witnesses to give evidence to the police and to the court (MoJ, 2022a).

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- ISVAs and advocates must advocate for the involvement of justice intermediaries where this would be beneficial. Where necessary, they should advise a client to appeal if communication needs have not been met.

### **III. Design inclusive services that are accessible to all.**

“My greeting was: ‘You’re going to have to wait outside in the rain while we put a ramp out.’ Well, they knew I needed wheelchair access. They got me through the door, then they yelled up the stairs: ‘Your wheelchair user’s here!’” (Olivia)

Disabled victim-survivors wanted to see upfront accessibility information for sexual violence support services to enable them to prepare for their first contact, but also because this can offer reassurance that the service was designed with disability in mind. They explained various accessibility features of an

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inclusive building. Physical and communication support were considered important for services to create a safe and accessible environment. Other factors mentioned included disability equality skills, training and experience in staff, including receptionists, how much time each victim-survivor is allocated with an advocate or counsellor, flexibility in offering online and face-to-face support, helpline support to be available out of working hours, the size of peer support groups and room set up. Disabled victim-survivors recalled feeling isolated during wait times for services. Some had experienced excellent creative support groups offered to them during wait list times.

### **Recommendations:**

- Development of a checklist for assessing the accessibility of sexual violence support services. This should require services to provide upfront accessibility information;

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- In-depth disability equality skills training for all staff, including receptionists;
- Enhance accessibility (e.g. changes to the built environment, development of information about services in accessible formats);
- Flexibility in service delivery should allow additional needs to be met (e.g. extra time, smaller groups, 24/7 helpline support, online and face-to-face support alternatives, creative solutions to help fill wait times).

### **IV. The victim-survivor at the centre of service design and delivery.**

“It’s multifaceted, it’s multi-layered, it’s like, adverse childhood experiences of being in care, abuse, disability, race and, the incidents themselves and you can’t just tease one out and say: ‘Ah well, forget all the others.’” (Carly)

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Disabled victim-survivors who participated in this research wanted victim support workers to be ready to challenge the multiple forms of disablism that may affect them and to work with them in a holistic manner. This means taking account of access needs and personal histories, including multiple and repeat incidents of violence and abuse. Respondents wanted services to understand that each victim-survivor expresses trauma differently. They reported that barriers to accessing support were often exacerbated by the interplay of multiple and overlapping aspects of their identity, such as age, sex, sexual orientation, ethnic group and economic activity. Many wanted to be supported by a diverse staff team, so that they could recognise themselves as represented within the service.

Respondents shared positive experiences of support that had put them at the centre of service delivery. Specialist victim support advocates and ISVAs helped

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to increase the consistency of positive experiences, as their brief was to work in a person-centred manner. The diverse experiences of respondents indicated that it is crucial that advocates and ISVAs are allocated at the right time and have the time and resources to respond to the victim-survivor's needs in full, in accordance with the Enhanced Rights as outlined in the *Code of Practice* (MoJ, 2021b).

### **Recommendations:**

- Development of a best practice toolkit which should include a checklist for services to self-monitor their engagement with anti-discriminatory practice;
- Encourage the recruitment of a diverse staff team;
- Sharing of good practice examples to enable learning across the sector, for instance via regional events;

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- Disability equality skills training for staff must include intersectionality;
- Increase the number of specialist ISVAs with reduced caseloads.

### **V. Work in partnership with disabled victim-survivors.**

“Even if they [other survivors in a peer support group] don’t necessarily see themselves coming across like that, you can feel it and you can sense it, that they are pitying you. Whereas if I was in a group with all disabled people – or even four, five disabled people, it would make me feel an awful lot more comfortable.” (Sylvia)

Roughly half the respondents had a strong preference to be supported by another disabled person. These victim-survivors felt more relaxed around other disabled people, and they had a feeling of belonging within services that advertised themselves as being

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inclusive of disabled people. Many were keen to have the option of using a *by* and *for* service.<sup>3</sup> A significant proportion of the disabled victim-survivors who participated were enthusiastic about getting involved in service design and/or delivery, for instance, by acting as peer supporters or by advising on the accessibility and design of their local services.

### **Recommendations:**

- Work in partnership and consult with disabled victim-survivors and their organisations or networks on implementing the recommendations under I-IV;
- Offer mentoring and training programmes for disabled victim-survivors to become peer supporters, including within or attached to support services;

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<sup>3</sup> 'By and for' services are specialist services that are led, designed and delivered by and for the users and communities they aim to serve, for example disabled victim-survivors.

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- Seed fund and enable the development of more *by* and *for* services.

### **Box 1: Almost getting it right? – Lucy’s case study**

Lucy is D/deaf. After Lucy was raped she texted 999. The police arrived promptly and took her to the sexual assault referral centre (SARC). Here, a crisis worker stayed with her throughout to “hold your hand and explain to you what they’re actually going to do”. Occasionally officers forgot about Lucy’s communication needs, but the crisis worker “was better at remembering”. For instance, the person who conducted her physical examination wore a face mask, but Lucy needs to lip read. The crisis worker therefore repeated instructions that Lucy needed to understand to complete her forensic medical examination. Overall, Lucy asserted: “They tried to make the experience as positive as it could be.”

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The suspect was charged, then released on bail until the trial. His bail conditions included not being allowed within the perimeter of Lucy's area, but she felt unsafe: "I felt scared that I might bump into him. So, I stopped going out and I started to become really unwell mentally." At this stage, Lucy had still not been referred for support. "After a month from when it happened, I was like, I can't do this, this is stressing me out. So [the detective] said I would benefit from an ISVA, an independent sexual violence adviser." The detective made a referral, and the ISVA visited the following day:

“She had worked with one D/deaf person before, but she said, ‘Every D/deaf person has different needs, how can I best support you?’ I said text, emails, face-to-face contact. So she did, she came to see me every week, whether she had anything to tell me or not. She still came and offered emotional and practical support. She even Facetimed me. [...] If I was having a bad day, she’d say: ‘I’ll come this afternoon at two o’clock.’ She helped me get through that horrible time.”

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In accordance with the Victim's Code (MoJ 2021b), Lucy's needs should have been assessed during initial contact and recorded on a MG11 Witness Statement,<sup>4</sup> and the Special Measures required for her to attend court applied for by the CPS and agreed before the trial. It appears that this was not done, as Lucy encountered several barriers in court and her ISVA helped negotiate on her behalf:

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<sup>4</sup> One purpose of this form is to identify any needs for special measures for vulnerable and intimidated witnesses.

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“I had a microphone that connects to my hearing aids and my cochlear implant.” The court said: “We’re not sure if we can allow this in court. We don’t know if it’s a recording device.” [...] My ISVA called the cochlear implant team to get them to write a quick letter and email it to us, to explain what this microphone was. The judge got the letter, and he said: “Fine, yeah, you can have it.”

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The support from the ISVA and the detective gave Lucy the strength to go through with her court case. The defendant was convicted. Her case demonstrates that sometimes victim support services get it right, but Lucy's consistently positive feedback on those who were supporting her case were the exception amongst respondents in this research. Moreover, she described that she needed support to fight a battle against a CJS, which was ill equipped to meet her needs. This battle could have been evaded had her entitlements under the *Victim's Code* (MoJ, 2021b) under Right 4 and Enhanced Rights been met. Findings throughout this report reflect that many respondents did not receive the rights they were entitled to, which has driven many of the recommendations within the summary and conclusion.

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## 2. Introduction

### 2.1 D/deaf and disabled people and sexual violence

The Ministry of Justice conducted a wider research programme in the context of a public commitment in the *Rape Review Action Plan* (MoJ, 2021a) to undertake targeted research with victim-survivors of sexual violence to better understand their support needs. This identified a distinct evidence gap in relation to qualitative research with disabled victim-survivors, which lead to the commissioning of this research. The *Rape and Sexual Abuse Support Fund* (MoJ, 2019) provides grant funding to rape and sexual violence support services in England and Wales. The findings and recommendations of this research will help to inform recommissioning to help ensure it meets the needs of all victim-survivors.

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There is a need to ensure that support services have the means to meet the needs of disabled victim-survivors. A variety of studies have shown that disabled victim-survivors can often feel let down by support services and have fears of being institutionalised or having their children taken away if they report violence and abuse (Hague et al., 2011a; 2011b; Shah et al., 2016), whilst professionals may feel less confident in supporting disabled victim-survivors to access appropriate services (Fraser-Barbour, Crocker & Walker, 2018). Disabled victim-survivors of sexual violence have been identified as underserved by formal support systems (Bach et. al, 2021). This research was therefore conducted to provide important insight into the barriers faced by disabled victim-survivors when accessing support services and what can be done to meet their support needs. This is especially important, given the

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increased likelihood of disabled people to experience sexual violence.

Data from the Crime Survey for England and Wales (CSEW, 2019<sup>5</sup>) indicates that disabled people aged 16 to 59 are almost twice as likely to have experienced sexual assault in the past year than non-disabled people (3.7% vs 1.9%). It also indicates that sexual violence is a gender-based crime: 5.7 per cent of disabled women experienced sexual assault compared to 1.1 per cent of disabled men. The inaccessibility of mainstream survey instruments can exclude some disabled people from completing the CSEW (Balderston, 2013). CSEW only collects data for people in households, which excludes disabled people in communal living, such as care or nursing homes, assessment and treatment units, psychiatric or other hospital settings and communal supported

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<sup>5</sup> At the time of writing with was the latest ONS release on disability and crime.

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living. Evidence suggests that disabled men and women in psychiatric services are more likely to experience sexual violence than the general public (Disability Wales and Welsh Women's Aid, 2019).

Khalifeh et al. (2016) found that roughly 10 per cent of women and 3 per cent of men with severe mental illness had experienced recent sexual violence.

Therefore, an unknown proportion of disabled adults are not included in these statistics and the rate of sexual violence against disabled people could be higher.

Research also suggests that beyond sexual violence, disabled people are exposed to a higher incidence of all forms of interpersonal violence and are therefore more likely to experience multiple disadvantages (CSEW, 2019; Disability Unity, 2021). Causes for increased victimisation rates amongst disabled people have been linked to structural inequalities and contextual factors (Hollomotz, 2013). For instance,

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disabled people are exposed to a wider range of potential perpetrators, including informal and formal caregivers, such as health professionals and family members (Breckenridge 2018). Within such relationships disabled people are more likely to be exposed to imbalanced personal relationships and restricted autonomy. Hollomotz (2011, 2013) also observed a higher tolerance for maltreatment within segregated settings. Shah et al. (2016) add that from childhood on, disabled people are socialised into compliance. As a consequence, the boundaries between acceptable and unacceptable means of being treated may become blurred for some. This evidence base informs the College of Policing (2021) guidelines in relation to vulnerability-related risk, which defines a person as “vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation”. This definition is underpinned by

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an understanding that vulnerabilities interact with specific situations, which may increase or work to counter-act risk of harm. The CPS (2021) furthermore caution about the use of the term “vulnerable”:

“labelling has been repeatedly criticised by disabled people and others and is not in line with the social model of disability. [...] use of this label can give the message that disabled people are inherently ‘weak’ or ‘dependent’ as individuals and as a group, when in fact it is physical barriers and social attitudes that create inaccessible, unsafe and therefore vulnerable situations for disabled people.”

## **2.2 Overview of this report**

The aims and objectives of this research were

**(1)** to give voice to the lived experiences of disabled victim-survivors;

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- (2) to be accountable to disabled victim-survivors and to the social model of disability;
- (3) to make actionable recommendations for changes to commissioning that can help enable victim-support services to meet the needs of disabled victim-survivors.

The research delivered on these aims and objectives by asking the following questions:

- Q 1:** What do disabled sexual violence victim-survivors want from victim support services?
- Q 2:** What do they consider to be effective in helping them (a) engage with the criminal justice process and (b) cope and recover from the crime?
- Q 3:** How can sexual violence victim support services become more inclusive?

Chapter 3 sets out the methodology adopted in this research and Chapters 4 and 5 present the findings. Chapter 4 outlines how the histories of disabled victim-survivors and intersectionality can impact how

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and if they access support services. It also presents some of the most common barriers respondents in the research encountered in terms of attitudes, communication and access. Chapter 5 discusses solutions for meeting these needs and overcoming disabling barriers by providing clear recommendations. These are grouped into four distinct work packages, as summarised in Figure 7 in the conclusion: the development of a toolkit for driving change, changes in commissioning, flexibility in funding allocation and service design.

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## 3. Methodology

### 3.1 Key definitions

This research is about disabled adult sexual violence victim-survivors in England and Wales. Throughout the report the term ‘victim-survivor’ is used for consistency. It refers to any complainant or victim of sexual violence. The term “sexual violence” is used to encompass all/multiple forms of rape, sexual assault and abuse.

Civil law considers a person to be disabled if they have a physical or mental impairment that has a substantial and long-term effect on their ability to do normal daily activities (Equality Act, 2010). The following impairment categories from the *Impairment harmonised standard* (Government Statistical Service, 2020) were included in this research:

- **Vision** (for example blindness or partial sight)

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- **Hearing** (for example deafness or partial hearing)
- **Mobility** (for example walking short distances or climbing stairs)
- **Dexterity** (for example lifting and carrying objects, using a keyboard)
- **Learning or understanding or concentrating**
- **Mental health**
- **Stamina or breathing or fatigue**
- **Socially or behaviourally** (for example associated with autism spectrum disorder (ASD) which includes Asperger's, or attention deficit hyperactivity disorder (ADHD)).

Many disabled people have more than one impairment, not all impairments are visible and not all disabled people identify as disabled. For example, the D/deaf community identify as a cultural and linguistic minority.

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In line with the disability movement's core principle 'nothing about us without us' (Charlton, 1998), this research was co-produced by two universities and two organisations of D/deaf and disabled people. This partnership enriched the research process by holding it accountable to the social model of disability and to disabled victim-survivors, enabling direct input by D/deaf and disabled people's organisations into the research process. The CPS (2021)

“understands the social model of disability to mean that the prejudice, discrimination and social exclusion experienced by many disabled people is not the inevitable result of their impairments or medical conditions, but rather stems from specific barriers they experience on a daily basis. These barriers can be environmental (inaccessible buildings and services), attitudinal (stereotyping, prejudice and discrimination), and organisational (inflexible policies, practices and procedures).”

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This social model can be used as a tool to challenge disablism, discrimination and exclusion, with a view to enable the design of inclusive services, which have the capacity to be responsive to the needs of disabled victim-survivors. However, disability is only one of several factors that shape the experiences of and institutional responses to disabled victim-survivors. This research adopts an intersectional approach that takes account of the intersection of disablism, racism, sexism, homophobia, ageism and other forms of oppression and discrimination (Thiara and Bashall 2021).

This project adhered to the Leeds University ethics and safeguarding policies, the British Sociological Association (2017) Statement for Ethical Practice and to the Ethical Principles in the Government Social Research (2021) Professional Guidance. It received Leeds University ethics approval. Further information about ethics can be found in Appendix A.

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## **3.2 Participant recruitment and sampling**

The research population were disabled victim-survivors of sexual violence from across England and Wales who had experienced sexual violence aged 16 or over.<sup>6</sup> This includes those who have and who have not accessed victim support services and also victim-survivors who have reached different stages in the criminal justice process, from not reporting, through to successful conviction. Those with an active criminal justice case were excluded.

Due to the urgency to produce findings in time for the recommissioning of the Rape and Sexual Abuse Support Fund (MoJ, 2019) this research was conducted across an unusually tight timeline for qualitative research (seven months from start to finish). Participant information was developed in

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<sup>6</sup> The Independent Inquiry into Child Sexual Abuse (IICSA) have led work on child sexual abuse, which is considered in the process of recommissioning.

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multiple formats, including large print, spoken word, Easy Read and British Sign Language (BSL), as well as a subtitled, BSL-interpreted video of the research team explaining what to expect from the interviews and focus groups.<sup>7</sup> A Twitter account was created specifically for this research project. This social media platform was used to advertise the study to potential respondents as well as relevant support organisations. All Tweets were agreed with MoJ before being published. They prioritised concise, clear and accessible information.

In addition, the research team proactively networked with around 50 potential gatekeepers (victim support and disability organisations). This involved personalised initial contact via e-mail, at times via introduction by MoJ, other academics or practitioners within the research team's networks, as well as an

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<sup>7</sup> These resources can be accessed here: <https://survivors-project.leeds.ac.uk/>

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element of snowballing from one service who offered to help to another. Where possible the team met with service managers to explain the research. Appendix B provides further detail on recruitment.

A purposive sampling strategy was adopted, which combined some elements of maximum variation with criterion sampling (Patton, 2014). Especially given the tight timeline, the final sample needed to be of a size that was manageable in practical terms (Mason 2018). Emmel (2013:140) further explains that “qualitative samples are invariably small because in collecting rich insight these data will be bulky”. However, the aim was to include a diverse sample. Participants had a range of physical impairments, sensory impairments, mental health difficulties, neurodiversity, speech impairments, learning disabilities – many had multiple. If mental health was a person’s only impairment, they were only included in this research if their condition existed prior to them experiencing sexual violence.

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The research also aimed for a geographically diverse sample across England and Wales and to include victim-survivors who had reached different stages in the criminal justice process. Targeted efforts were made to recruit males, respondents from Wales, BME communities and D/deaf BSL users and these were partially successful.

Around 50 victim-survivors contacted the research team directly about taking part. At least a further dozen potential cases had been discussed with gatekeepers but decided not to come forward. Some of those who contacted the researchers changed their mind. Others were screened out due to not meeting the sampling criteria. At the end of the recruitment window only those who were from under-represented groups were accepted. Thirty of the fifty individuals who had approached the research team completed an interview. Two additional focus groups were conducted with 4 and 5 respondents each.

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Recruitment for focus groups had been directly negotiated by the gatekeepers (see Appendix B). An overview of the demographic details of the 39 respondents is presented in Appendix C.

Most respondents (34 of 39) had used victim support and sexual violence support services. This included a spread of organisations awarded funding from the Rape and Sexual Abuse Support Fund (MoJ, 2019), as well as other victim support services. Services are not named in this report to protect the anonymity of respondents. They included a range of victim support services for adult victim-survivors, such as Rape & Sexual Abuse Support Centres, Rape Crisis services, Women's Centres and also specialist services for disabled victim-survivors.

### **3.3 Data collection**

Respondents were asked about their access needs prior to the interviews. Meeting needs included

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sending questions in advance, asking questions differently, offering face-to-face alternatives, booking a palantypist, meeting the interviewer in advance, or pausing the interview to ease anxiety. Some required time slots outside working hours or to rearrange interviews. Respondents had the option of being interviewed by a man or woman or non-binary person, and by a disabled interviewer. Speakup,<sup>8</sup> a user-led organisation, translated the participant information sheet, consent form, screening questions and interview questions into accessible formats for people with learning disabilities.

Interviews were held at a time and place convenient for the respondents. Twenty-six interviews were conducted online via Zoom. Two were conducted online via Teams, as this offered better captions for D/deaf respondents. Most participants conducted their online interviews from within their home. Two had

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<sup>8</sup> <https://www.speakup.org.uk/>

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travelled to a victim support organisation and were supported by a support worker throughout the interview. Two interviews were conducted face-to-face. The focus groups were conducted face-to-face, co-facilitated by two interviewers. Interviews lasted between thirty minutes and two hours. Length depended on whether or not victim-survivors had accessed support services and/or the CJS, as well as their level of articulacy and in some cases, time restrictions. Although respondents answered roughly the same set of questions, the interviews were led by the respondents, who valued the opportunity to share their experiences.

Respondents were given the option of using creative methods to revisit, piece together, and re-story their experiences in a safe, supportive, and collaborative environment (Burch, 2021b). A 'snakes and ramps' board akin to the popular board game 'snakes and ladders' was used to create a visual representation of

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the process of accessing and receiving support, and to encourage conversations about experiences at different points of this journey. It was created using Jamboard online or a physical board in face-to-face interactions. The board captured the 'messiness' of this journey and highlighted both barriers (snakes) and opportunities (ramps). (See Appendix F for an example.)

Creative methods should not be enforced. It is important that a choice is provided for both the interviewer and respondent. Some of the interviewers did find these difficult to manage online via Zoom and some respondents opted not to use the board when offered, resulting in a third of respondents using it. However, all interviews were structured around similar questions in relation to the victim-survivor's journey towards accessing support, some with and some without using the 'snakes and ramps' board as a concrete prompt.

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All respondents participated in the second creative method, the Miracle Question (De Shazer 2021). They imagined an “ideal” victim support service and walked the interviewer through the service, detailing how they would access it, how they would be greeted, what the space would look and feel like, and how it would meet their access needs. Appendix D provides more detail.

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### **3.4 Data analysis and report writing**

All interviews and focus groups were recorded and fully transcribed. Transcripts were distributed within the primary research team (the authors of this report), which helped to ensure familiarity with the wider dataset. Transcripts were read and re-read and thematically analysed to identify similarities and differences in respondent accounts. Themes were coded using NVivo and included parent and child nodes. A loose coding framework was established which was revised and reinterpreted throughout the coding process. This framework was iteratively developed as the team engaged with the evolving dataset. Draft versions of these themes were shared with MoJ. Ongoing discussions about these helped to prioritise themes most closely related to the research questions and of most use to recommissioning. A more detailed overview of the coding strategy can be accessed in Appendix E.

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The purpose of this research was to report solutions and what works, as this focus is of most use to commissioners. This meant that data on negative experiences was proportionally reduced and only provided to add context for explaining why specific solutions were needed. Therefore, as is common for much research, this report does not include findings on all themes that were covered by respondents, but does represent a fair and balanced representation of key findings relevant to the research questions.

Care was taken to include the voices of all respondents in this report. The study included a wide range of people who presented with differing modes of communication. Some spoke extensively about their experiences. Others articulated their experiences using concise or repetitive language. All were of equal value and provided rich data.

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### **3.5 Limitations to the study**

Recruiting of respondents was challenging and due to the tight timescales, some groups were not possible to include in the sample. Spring 2022 was also a demanding time for overstretched support services in the context of Covid-19 and a steep rise in referrals, but some made a prodigious effort to support respondents to take part (see appendix B).

The findings that are shared in this report are not generalisable to all disabled victim-survivors. Please see 3.2 for the inclusion criteria in this study.

Moreover, the experiences of respondents who took part in this research may not be reflective of all services. There is a changing landscape of services, which means that an experience described by a respondent during fieldwork several months prior to completion of the report would be different if they sought support at the time when this section was written. Most of the organisations who acted as

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gatekeepers to this research were victim support organisations, which means that the data is skewed towards reporting the experiences of individuals who have accessed such services. The respondents reported on accessing counselling and talking therapy, such as Cognitive Behavioural Therapy (CBT), as well as peer support groups and art therapy. Further coping and recovery interventions which are evidence-based for survivors of sexual violence (e.g. Eye Movement Desensitisation and Reprocessing (EMDR), music, etc.) were not discussed by respondents. These are however part of the solution and further research should explore disabled people's experiences of accessing such interventions.

Moreover, some of the experiences recounted by respondents as part of their help-seeking journeys, such as that of reporting to the police, were side-lined in the writing up of this research, which prioritised data

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that directly contributed to answering the research questions in relation to victim support services. Separate outputs are planned for this data. Five respondents had not accessed support. This report makes only limited progress in explaining their experiences. Moreover, using services as gatekeepers may have resulted in proportionally more victim-survivors who had positive experiences coming forward. Finally, respondents in this research include only those people with impairments who self-identified as disabled.

Despite the research team including two black interviewers, the researchers who publicly promoted the study were white, which may have discouraged some. Only one Black African respondent and no Black Caribbean respondents were recruited. The research aimed to include five male respondents, but only three who came forward met the sample criteria. Over half the males who approached the research

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team had been under the age of 16 at the time of their sexual violence experiences. Despite considerable efforts made to recruit respondents from Wales, the final sample included only two Welsh respondents. Disabled people living in communal establishments, such as supported living accommodation, were less likely to notice the call for participants. Seven respondents living in communal establishments at the time of the research were included.

As outlined in 3.2, recruitment of disabled victim-survivors who were in a position to share their experiences was a laborious part of this research. The team hoped to also include D/deaf BSL users and the research partner organisation SignHealth made considerable efforts to reach out to the D/deaf community. The sample included six respondents with hearing impairments, three of whom identified as D/deaf. One respondent was a BSL user but preferred spoken means of communication for the interview.

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Many of the BSL users who were approached about the research said that they had been denied access to the services which would aid them in their recovery. This begins with the initial contact with police, the CPS, and includes the process which leads them towards a search for trauma-informed counsellors who can communicate using BSL. Although they may be open to the prospect of contributing to on-going research, these systemic barriers can prevent D/deaf victim-survivors from being ready to share their experiences. SignHealth explained that this had also been experienced with other projects.

The final set of limitations relates to the format of this research report, which centre-staged the voices of disabled victim-survivors. This research report prioritises the primary research findings from respondent accounts. There was limited scope to bring in comparisons to existing literature and the policy landscape. Findings and recommendations

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from this report must therefore be considered alongside all the three strands of the research programme conducted by MoJ.

## **4. Challenges for disabled victim-survivors when accessing support**

This chapter presents the challenges and barriers faced by respondents relating to their histories and intersectionality, as well as barriers which prevented them from accessing support services and therefore impacted on their ability to cope, build resilience, and move forward with their lives from rape and sexual violence. The findings presented here offer the context for those presented in Chapter 5 around respondents' views on solutions.

### **4.1 The histories and intersectionality of disabled victim-survivors**

Respondents reported hurtful experiences of being treated differently because of their identity. For

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instance, Julie stated: “I’ve been ‘othered’ for my entire life.” Sarah reflected:

“Even just something as simple as boarding the bus on my wheelchair. I’ll get a lot of watch consulting and finger tapping and just general tutting. People don’t understand how aggressive that is when they do it.”

Multiple incidents of othering accumulate and change the way that disabled people feel when accessing certain spaces (Burch 2021a). Many disabled people come to services with a plethora of negative experiences with services and organisations, and this shaped their opinions of the support services provided. Noor explained:

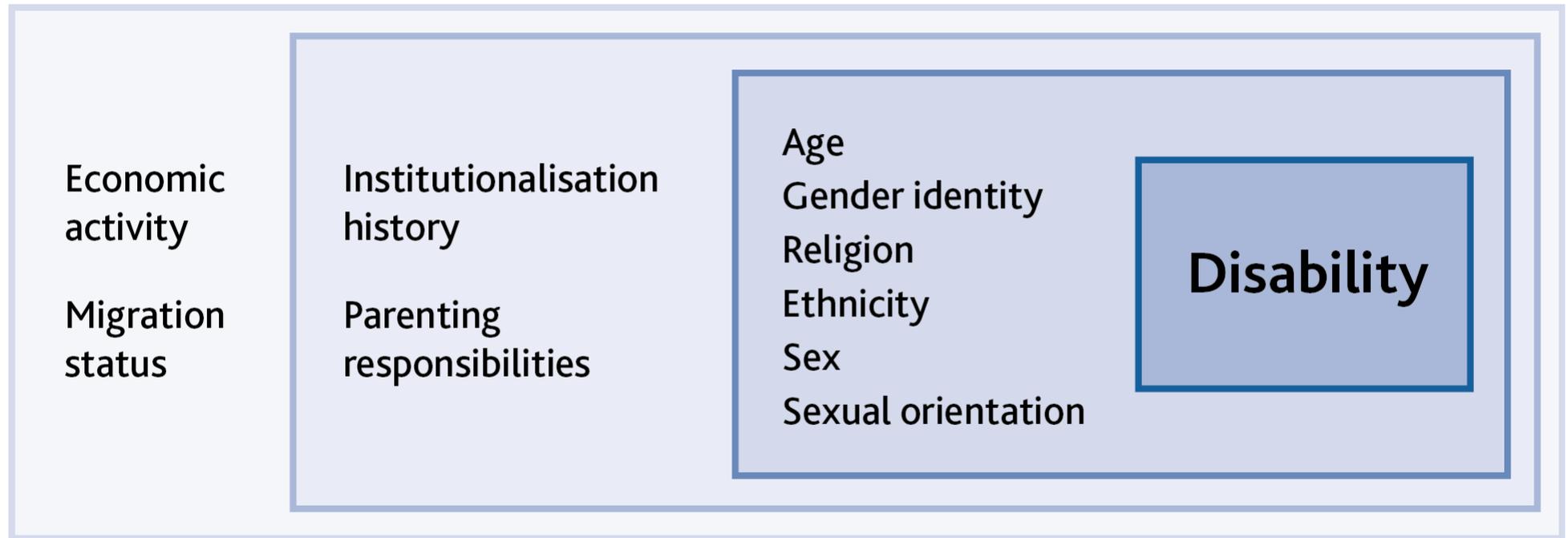
“I have had so many bad experiences with these authorities, especially police. I cannot stand them. I hate them so much. [...] Especially if

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you're a person of colour, especially if you're a person from a particular religion or background.”

For many, sexual violence was one of several adverse interpersonal experiences (Hollomotz 2013). Some had also experienced hate crimes, domestic and institutional abuse or their children being taken from them. A few respondents experienced sexual violence at different times in their lives and by multiple perpetrators.

**Figure 1: Intersecting identities**



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Balderston (2013:43) argues that an intersectional analysis can help to unpack the oppressive and cumulative effects of intersecting oppressions. Some intersecting identities are illustrated in Figure 1.

Intersectionality describes how social divisions can overlap, creating multiple levels of social injustice (Crenshaw 1991). Carly was an ethnic minority woman who grew up in care. She had physical impairments, learning disabilities, mental health difficulties and she was neurodiverse. She was one of the respondents who struggled the most with being believed when accessing victim support services, and she reported repeat experiences of victimisation.

This was significant, as she had no family support.

Carly reflected:

“It’s multifaceted, it’s multi-layered, it’s like, adverse childhood experiences of being in care, abuse, disability, race and, the incidents

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themselves and you can't just tease one out and say: 'Ah well, forget all the others.'

Many female and non-binary respondents who reported to the police recounted negative experiences of “victim blaming” and not being allocated female support staff, even when they expressly asked for this. Kate explained: “When you talk about intimate things, it's really hard to do that with a male, however nice they are.” In contrast, Thomas felt that as a male survivor he had been ignored and questioned: “Why weren't there more people to listen to my story, to help me, was it because I was a man? Was it because there was some shame?”. Thomas struggled to find a service that would work with him as a disabled, male survivor of sexual violence and had been told: “Sorry, we only deal with women.” (See Appendix G for a full description of his journey.) Thomas was only able to access a treatment programme that helped him heal after he committed a violent offence. He believed that

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he would not have hit crisis point had support been available earlier.

Fatimah added that domestic abuse by her husband was accepted within her family and seen as the wife's "fault". She could not see a way out, because of family honour. In fact, her husband pointed out how powerless Fatimah was as he was being violent:

"He would always say words to the effect of: 'So what are you going to do, call the police, yeah? Let's see you try.' And I think the reason for saying that was just to emphasise how much worse the repercussions were going to be if I did do that."

In discussing barriers to seeking support, Noor linked gender to ethnicity: "I think it's much more hidden in our Asian community because it's seen as usually the female's fault and there's this stigma and negativity attached to it". On the other hand, Noor had

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experienced racism in the charity sector. She felt she had repeatedly been treated differently because of her ethnicity. In one case, the sexual violence experienced was an anti-lesbian hate crime known as ‘corrective rape’ (Anguita, 2012): “The perpetrators knew that I identified as a lesbian. And they tried to convert me by doing what they did.”<sup>9</sup>

Some respondents commented on the interaction between sexual violence and parenting. Lesley described how the police referred her to children’s services when they were investigating domestic and sexual violence. She recalls that her own seemingly irrelevant history of experiencing child sexual abuse was brought up and she wondered: “Would children’s services have turned round and said that I couldn’t keep my child safe?” Blessing’s child was taken into care, as she was deemed “unfit” to parent due to her

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<sup>9</sup> This account of violence is not linked to the respondent pseudonym to keep it detached from other identifying information.

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mental health, which subsequently got much worse.

This led to her becoming homeless and then being raped by someone who took advantage of her

situation. Lilly was separated from her young child.

Whilst the circumstances were unclear, the

impression was that this separation was as traumatic as the sexual violence she had experienced.

Social class also caused imbalanced power dynamics, which made some respondents wary of authority and support services. Bea reflected upon her working-class status:

“The abusers came from wealthy backgrounds.

They went to boarding school and all that.

Whereas for me my upbringing was very much working class [...] That was one of the biggest

reasons that I didn't pursue it, because they

would have had more financial resources to fight this than I did.”

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Roughly a third of respondents had experienced sexual violence by a partner. Some found that the services they tried to access for sexual violence were separate from those for domestic abuse.<sup>10</sup> Earlier in this section it was highlighted that past experiences of being ‘othered’ may make some disabled people more sensitive when approaching new settings. This may help to explain why some respondents did not feel that they belonged either in the sexual violence service, or in the domestic abuse service. This was most prominent in peer support groups. Grace had been subjected to physical violence, threats to their life and sexual violence by her ex-partner. She reflected on her experience of attending a peer group for sexual violence:

“Some of the people in the room have experienced rape, but very few have experienced

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<sup>10</sup> It is acknowledged that there are services available for victim-survivors of sexual violence in the context of domestic abuse, under the umbrella term VAWG.

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the level of violence and things around it. Then if I start talking about that everyone goes really weird and silent, and I feel like I don't belong.”

Sylvia was coerced by her husband into sexual acts she did not want and at times when she was in excruciating pain, for instance following surgery. She felt her experiences were not “the right fit” when attending a domestic violence peer support group:

“I went to [group], but I felt like an imposter. Because they were talking about all the stuff that they had been through, like, you know, been chucked down the stairs or things like that, and nothing like that had happened to me.”

### **Conclusion**

Disabled victim-survivors who participated in this research needed sexual violence support workers to be ready to challenge the multiple forms of disablism that may affect them and to work with them in a

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holistic manner. This means taking account of access needs and personal histories, including multiple and repeat incidents of violence and abuse. Barriers to accessing support were often exacerbated by the interplay of multiple and overlapping aspects of a disabled victim-survivors' identity, such as sex, sexual orientation, ethnic group and being a care leaver, but also contextual factors, such as parenting responsibilities and immigration status. Some victim-survivors did not always feel that all their intersecting identities could be accommodated within services. They wanted to be supported by a diverse staff team, so that they could recognise themselves as represented within the service. Those who had experienced sexual violence within a domestic context found it harder to find a service where they felt they belonged.

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## **Recommendations:**

- Services to self-monitor the extent to which they appear welcoming to a diverse client base and are engaging with anti-discriminatory practice;
- Services to encourage the recruitment of a diverse staff team.

## **4.2 Disabling barriers to accessing support**

This section discusses attitudinal, communication and physical access barriers, time expectations and restricted pathways into victim support services.

### **Attitudinal barriers**

All respondents encountered at least some hurtful disablist attitudes, ignorance and institutional barriers on their journey towards accessing victim support services and the CJS. The behaviours of neurodiverse respondents and those with mental health difficulties

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were often misunderstood. They struggled to be believed and to access services:

“Immediately a barrier came down, shutters came down... ‘You’re too complex for us’... Words were used like, ‘complex’ or ‘stabilisation’... they couldn’t just accept me as I was and what I was telling them”. (Carly)

Rose described professionals’ disbelief of the fact that someone like her could experience sexual violence. She was made to feel like “an extraordinary event, like this kind of thing just never happens” and “further alienated.” A lack of understanding of how sexual violence may specifically affect disabled people was also reported by Grace who believes that public ignorance about devotees<sup>11</sup> acts as a barrier to reporting: “It’s weird having to explain to a cop what a

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<sup>11</sup> Devotees are sexually attracted specifically to disabled people, due to what is understood as a fetishization of impairment (Aguilera, 2000).

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fetishist is.” Francesca felt that her counsellor “wanted to fix” her:

“They always came back to: ‘You must have felt so powerless because you’re visually impaired.’ They saw the fact that I had a disability, and they didn’t know how to cope with it and so they kept on coming back to it.”

**Figure 2: Being the only disabled person in a group**



Francesca wanted to be seen “as a victim of an assault, rather than a victim of disability”, but she felt like services “just didn’t know what to do with me”.

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Sylvia described being the only disabled person in a support group as “lonely”, as illustrated in figure 2:<sup>12</sup>

“Even though we had all experienced things, it felt like I was being looked down upon and pitied. But pitied from the place of being a disabled person, not being a victim or survivor. I didn’t need pity. Okay, I needed pity as a survivor maybe, but I didn’t need pity as a disabled person. I needed pity for what I’d been through.”

### **Communication barriers**

Sylvia’s physical impairment was visible, whilst her hearing impairment was not. The peer support group

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<sup>12</sup> The authors of this report commissioned the disabled cartoonist Dave Lupton (Crippen cartoons) to illustrate some specific barriers that were described by respondents in this research. These relate to the views and experiences of often just one respondent, so these images are not generalisable to all victim-survivors and all support providers. This report includes a total of four cartoons.

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was facilitated in a way that did not meet her access needs:

“The facilitator didn’t really help me. Because I’m hard of hearing, I find it very difficult to get in on conversations and make my point. Most of the time I just sat there in silence, didn’t really contribute anything, unless directly asked.”

Several respondents reported unsuccessful attempts to engage with Helplines. Quinn reflected: “It [victim support service] just kept ringing and ringing. It was within opening hours, and nobody picked up, I tried five times.” Other respondents felt Helpline opening times were inaccessible. For Kate opening hours did not work around her childcare commitments and Olivia needed support out of hours:

“Laying there in the middle of the night, for me that’s the worst time, when the busyness of the world stops, because if you did want support

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services, there's not that many available that can actually help that time of night."

In some cases, this depended on the type of helpline and its reach. Bea described her experience of a national helpline as "not the best" while a local helpline made her feel more at ease. She found the local accent easier to understand. This was similar for August who wanted to build rapport with a local service to build up trust towards accessing their face-to-face provisions. Helplines did not meet Carly's access needs: "They don't work for me with my autism, using the phone, explaining to a stranger." Bea recalled not being asked at all about her access needs, although she was asked demographic questions for monitoring purposes at the end of the call. At this point she disclosed that she had hearing loss. The assumption was made that Bea did not have access needs and even once she disclosed her impairment, this did not result in reasonable

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accommodations being offered. Sean described that some characteristics of his conversation partner can enable or hinder his hearing. He wanted to be supported by:

“Preferably by a male because they’ve got a deeper voice, not one with a beard because I can’t see their lips moving, and not somebody with a strong accent. I will struggle to see the formation of the lips. What did the counselling service provide? All three of them. His live transcript didn’t work, and he kept moving about.”

The counsellor’s lack of D/deaf inclusive communication skills created communication barriers, as illustrated in Figure 3. (Appendix F provides further details about Sean.)

**Figure 3: Not responding to communication needs**



Hazel was unable to access support from the victim and witness care team: "They left me a message and I never got back to him, because I couldn't read his log number." This acted as a barrier, as Hazel did not

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have the confidence to follow up her case without the log number. She did not have the support to read the log number. She was not contacted by an alternative means after she remained nonresponsive. Many of the other respondents indicated that their cases were discontinued by the police due to further communication barriers. Respondents with post-traumatic stress disorder and neurodivergence, such as Kate, Julie and Grace, had their cases closed because they were not presenting their account in a “linear enough fashion”. Julie explained:

“I have been so deeply entrenched in trauma that I could not tell you when my [child] got [their] first tooth. My memory is just absolutely appalling. But I know that particular things happened to me and if I am given the support to work through a timeline then I can begin to pin things down.”

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## **Physical access barriers and time expectations**

Many respondents encountered physical barriers when attending face-to-face support. They experienced noisy and clinical settings, stairs, doors that did not open wide enough for a wheelchair user, reception desks or doorbells that were too high, and information only available in limited formats. Olivia recalled attending her first counselling session:

“My greeting was: ‘You’re going to have to wait outside in the rain while we put a ramp out.’ Well, they knew I needed wheelchair access. They got me through the door, then they yelled up the stairs: ‘Your wheelchair user’s here!’”

This quote combines physical access barriers with hurtful attitudes, with Olivia being reduced to “the wheelchair” in need of “special” arrangements that made her feel like “a burden”. (See Appendix F for further details.) Being seen in a different room to others was a common experience amongst

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respondents with physical access requirements. Kate saw her counsellor in a cold, disused room, which was downstairs from the victim support service. Kate was disappointed not to have had the opportunity to meet other staff or clients and did not find out about other services on offer, such as ISVAs or support groups.

Rose explained that services made false assumptions around accessibility. When phoning venues in advance to discuss access, receptionists would assume that being step free equated physical access. Rose found that the SARC and the sexual health clinic did not have a hoist available to enable her to transfer to a gynaecological examination table.

“Normally it wouldn’t be an issue for me to explain what equipment is and what it does and how it helps me. But in that situation, you’re put in a position where you’re having to go into detail about how vulnerable and helpless you are

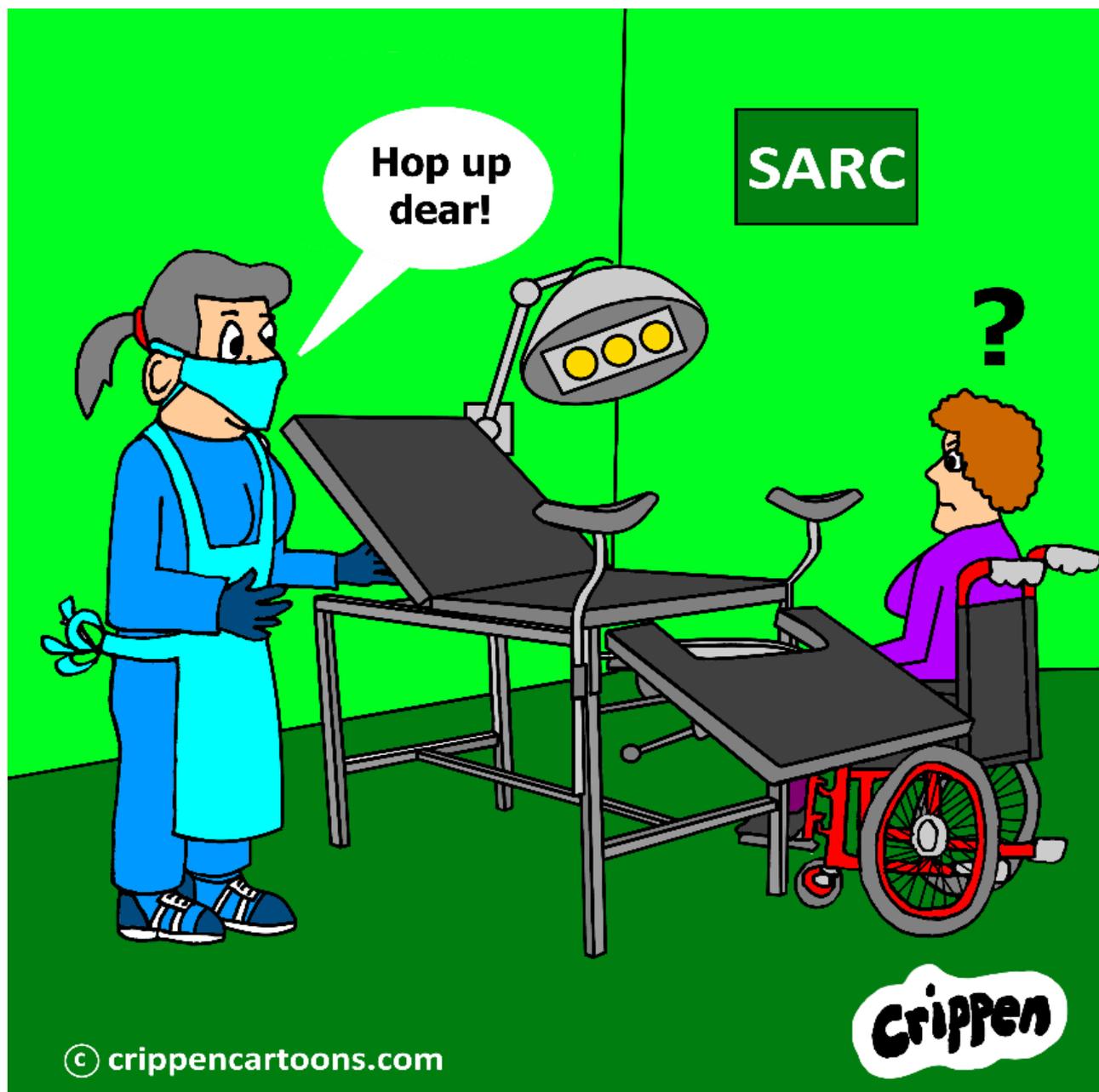
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because you can't move without a hoist. And that in itself was quite impacting.” (Rose)

Physical barriers can prevent access altogether.

Grace described: “I had to take the footplates off my wheelchair to get in the lift and try and get it in sideways, and then it sometimes wouldn't close and work. It physically stopped it.” The lift only moved if the “up/down” button was continually held down, which was physically challenging for Grace.

Figure 4: “How am I going to manage that?”



Several respondents found time expectations within victim support services unrealistic. When Nina’s support came to an end she felt as though she had “more work to do”. Anna needed greater time flexibility

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that would allow her to “talk about it at her own pace”.

Dorothy expressed her desire to have accessed art therapy for longer:

Dorothy: The arts therapy stopped. [...] I was a bit sad that it had to come to an end.

Interviewer: Would you have wanted longer?

Dorothy: Yes, I would have accepted longer, but it wasn't available because there was another person needing it.

It is important to read between the lines with respondents like Dorothy. Like many women with learning disabilities, she appears to have been socialised into compliance (Shah et al., 2016).

Dorothy was very polite and what she meant to say when she said that she is “a bit sad” was that she was devastated. As the interview unfolded and Dorothy relaxed into the conversation, it became apparent that

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there was some real disappointment, anger and even rage underneath this politeness. Fatimah reported lack of trust as preventing her from engaging with services. Building trust takes time and for some disabled victim-survivors it will take longer, either due to their access needs or due to their histories. Tracey asserted that “I have my barrier up until I feel comfortable enough that I can trust them”. Olivia stated that, “trust has to be earned”.

Fatimah brought up the impact of lack of reasonable accommodations to enable disabled people to work in the victim-survivor sector. She had lost a job where she was developing an honour-based violence toolkit: “I told them that I had mental health issues and they used it against me when I was vulnerable.” After Fatimah won a disability discrimination employment tribunal, she was too disheartened to return to work, as Fatimah felt unsupported and like she was the only disabled person in her workplace.

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### **Restricted pathways into victim support services**

“They put stickers on toilet doors in pubs and clubs and everything for helplines. I’ve never seen one in the accessible disabled toilet. Never. They forget to put it in there because, obviously, disabled people don’t get sexually or domestically abused. But we do.” (Nancy)

Nancy describes being forgotten about, which may in part help to explain why this project struggled to recruit disabled victim-survivors through some of the sexual violence support services that were approached. For instance, one service provider disclosed in a personal communication with the lead researcher that they had “exceptionally low numbers” of disabled clients. Yet this service was located in an area that has statistically a higher proportion of disabled people (Nomis, 2022). It has much work to do to reach victim-survivors like Nancy.

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Without effective referrals into victim support services, the specialist knowledge they hold remains unavailable to several of the disabled victim-survivors. Carly explained: “Often there’s talk about different helplines or organisations. You find they’re all doing the same thing and that’s not listening to people [...] it’s a signposting roundabout of nothing.” Sean’s GP was unaware of accessible local services. His wife contacted the Royal National Institute for Deaf People to be signposted to a specialist service. Sean is less savvy navigating the internet. Without his wife’s support, he would not have been able to find support. Quinn highlighted that signposting information to individuals who are in immediate crisis is ineffective when they reflected upon their experience at the SARC:

“It’s the most dehumanising thing I have ever experienced. Your body becomes a crime scene. [...] I remember breaking down in the bathroom

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after. And then they tried to explain all the different aspects and they hand you this booklet, and the last thing you can do after that is really hear all the things they're saying or read through a booklet. It's just so overwhelming."

There was no ISVA available to Quinn when they had their examination at the SARC. In retrospect Quinn thinks that information about ISVA support may have been in one of the information booklets they were given, but they were not in a position to make sense of this. Francesca raised a similar point: "A lot of people were just like: 'Oh well, this option is out there if you want to' and then that's the end of it because at the time, I didn't proactively know how to do things". Inga regretted having turned down an offer for a referral to a victim support service made by the police early on, as she was then left without support or follow-up. She described that since the sexual violence: "My life has been completely dysfunctional.

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[...] every single part of my life, not just my body, not just my mind, but my relationships, my capacity to earn, that was ripped away from me.” Inga dropped out of college following the sexual violence, whereas she had previously achieved top grades and was planning to set up her own business:

“At some point, there should have been somebody checking in and saying: ‘Okay, in a year or two time when you’re a little more capable, how about we send you to college to finish off your course, and you can then take up where you’ve left off’.”

Blessing experienced sexual violence from another user of her day centre. She was a homeless asylum seeker and the abuser had offered Blessing shelter, then demanded sex as “payment”. When Blessing told the day centre, they said there was “nothing they could do”, as it did not take place on their premises. This appears to be an example of exceptionally poor

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practice. They did not suggest contacting a victim support service. Blessing felt that her immigration status acted as a barrier to her reporting to the police:

“If I report it to the police, the issue about my immigration status being unsettled and everything will come into play, I could be picked up. I’ve already lost my [child] and I’m trying to keep it low profile so I could continue with the contact.”

Blessing feared the police might deport her and that social services would put an end to the remaining contact with her child. Whilst these fears may have been unfounded, Blessing felt that she was forced to continue living with the perpetrator.

Feedback from respondents who received support from safeguarding teams was mixed. For instance, after Kate reported the sexual violence, the police informed adult social care:

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“They basically had a safeguarding meeting about me. So, all the social services were involved and it was quite embarrassing to think that they’d all had this meeting about me before I’d even been interviewed by the police.”

In cases like Kate’s, the referral to adult safeguarding was done instead of a referral to victim support services, the assumption being that adult safeguarding would lead on these cases. However, these respondents then missed out on specialist advice and expertise available in sexual violence support services. For instance, for Kate and Paula the opportunity to make a timely referral to the SARC for a forensic medical examination was missed. Although Kate later accessed victim support counselling, she was not told about ISVA support.

### **Conclusion**

In line with the Code of Practice (MoJ, 2021b) disabled victim-survivors who report to the police

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should have had an initial needs assessment undertaken by the responding officer at the time of initial contact, but this did not happen consistently. Some respondents had a plethora of negative experiences with services, which made them more sensitive when they encountered staff who were inexperienced in working with disabled people. Some felt that victim support services had not been designed with disability in mind. Many had not been asked about access needs. Lack of accessibility can reduce victim-survivors' trust in services and make them feel like they do not belong.

## **5. Solutions for effective victim support for disabled victim-survivors**

This Chapter follows on from Chapter 4, which presented some of the challenges and barriers that disabled victim-survivor respondents encountered when accessing support. In this Chapter respondents report on solutions that can help to address these barriers and challenges, but also on their positive experiences when seeking support and what has helped them cope, build resilience, and move forward with their lives after sexual violence. This Chapter includes further examples of barriers encountered where respondent's accounts help to contextualise suggestions for solutions.

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## **5.1 Pathways into victim support services**

Over half of the respondents were opposed to signposting and wanted direct referrals. Signposting merely provides information about service options and relies on the victim-survivor's ability to initiate contact. Referral means a professional contacting victim support services on a person's behalf after they have discussed options with the individual and gained their consent. A few respondents were successfully referred, including by the police, mental health teams, social workers and advocates, but many were not. Being referred to victim support services by criminal justice agencies like the police is a right under the Victim's Code of Practice (MoJ, 2021b) and data from this research suggests that this needs to be better adhered to. As an honour-based violence survivor, Fatimah felt that a police referral can provide reassurance:

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“There’s that reassurance that when the police say: ‘What about contacting such and such a service?’ you kind of feel they wouldn’t be recommending that if they didn’t believe it was a safe organisation to contact.”

Lisa recalled a proactive approach for reaching out to her. She found out about the victim support service at a showcase event of local emergency services for people with learning disabilities and/or autism. She spoke to a worker from the service and told her that she would like to talk to her again. The victim support worker started visiting Lisa, who was gradually able to open up. This was the first time that Lisa felt able to disclose what had happened to her, despite that fact that she has had social care support throughout her life.

This is similar to Paula’s experience. Paula has a speech impairment. She uses communication boards and answers closed yes/no questions. Paula was

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trapped with a violent care worker during Covid-19 lockdown. Separated from her family and with no means to communicate effectively with the outside world she endured months of sexual violence.

Although family and carers noted changes in Paula's behaviours upon her return to family visits and the day centre, they did not provide communication cues that enabled a disclosure. Paula was eventually referred to a speech and language specialist who asked the right questions and continues to provide specialist therapeutic support. However, Paula was not referred to a community based sexual violence victim support service. Appendix H provides more detail on Paula's case, including failings to preserve evidence in a timely manner, which weakened her case. An ISVA could have helped by providing crucial guidance and advocacy.

A referral by Blessing's day centre to a victim support service could have helped her to break out of an

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abusive cycle sooner (more context was provided in section 4.2). For Blessing to consider this to be a viable option day centre staff would have needed to be knowledgeable about the remit of victim support services in working with those with an uncertain immigration status. Blessing would have benefitted from assurances about confidentiality. In the absence of a referral Blessing only accessed support much later, after she reached crisis point following a recommendation from another mental health service user. Both Blessing and Paula's experiences illustrate the need for long term, holistic support for disabled victim-survivors.

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Respondents who experienced sexual violence in care settings would have benefitted from input by a specialist sexual violence support service. Steven had not disclosed to anyone other than the interviewer. Although he wanted to tell his parent, he did not feel able to do so. He reported being too scared of the abuser to speak about what happened to him. Gina recalled how she tried to tell her consultant about sexual violence on a hospital ward:

“I said to my consultant, ‘Something serious happened to me when I was here, something really bad.’ And he said, ‘Yes, something serious did happen to you, your heart was about to stop.’ And I just – I think I just shut down.”

This was the first of several attempts that Gina made to disclose sexual violence by a nurse. Irrespective of consent, patient-nurse sexual contact is a criminal act under the Sexual Offences Act 2003. An impartial victim support service, such as a hospital ISVA, could

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have listened and helped her to feel safe again. This did not happen and Gina, who has a chronic condition, remained fearful about going into hospital. She reported letting her “pain levels get to an eight or nine [out of ten] before saying: ‘We need to go to hospital’”.

Willow highlighted that she would have wanted external support from a victim support organisation to take her side in an adult safeguarding investigation:

“You can actually phone up and go: ‘I’m being treated in this way, and I don’t think that’s quite right’ and so there’s an intermediary service that can then take on a case and go: ‘Yes your social services is behaving badly’, you phone them up, they tell them what they’re supposed to do because they’re not doing it.”

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## **Conclusion: Respondent's key expectations and specific recommendations**

Section 4.2 illustrated that many disabled victim-survivors who participated in this research felt they had been excluded from sexual violence support services from the onset, due to not knowing services existed or not trusting that these would be able to support a disabled person. This section added that respondents reported better outcomes when professionals were equipped to listen in the right ways to victim-survivors who were attempting to disclose abuse and when these services were then able to refer them to a victim support service, rather than merely signposting them.

Whorlton Hall and Winterbourne View (Department of Health and Social Care, 2012; Murphy, 2022) demonstrate that violence and abuse is, at times, not adequately addressed when it is uncovered within institutional settings. Steven's abuser had left the

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setting, but as the incidents were not reported, he is presumably working elsewhere within social care. Gina's and Paula's abusers were confirmed as continuing to work within care. Without effective referrals, specialist knowledge held by sexual violence victim support services was often not available to those in care settings. Disabled victim-survivors reported gaps in provision, such as not having access to an advocate or ISVA.

Current policies relating to the right to be signposted exist, including the Association of Chief Police Officers & Crown Prosecution Service (ACPO-CPS 2015) *Protocol* and the *Code of Practice* (MoJ, 2021b) but the experiences of respondents in this research were that and these were not consistently implemented. The *Serious Violence Duty* (Home Office, 2022b, p.7), asserts that "Serious violence has a devastating impact on lives of victims and families, and instils fear within communities and is extremely costly to society".

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It places duties on CCGs to assure delivery of serious violence prevention strategies.

### **Recommendations:**

- By strengthening liaison work with agencies who are required to deliver the *Code of Practice* (MoJ, 2021b), ACPO-CPS (2015) *Protocol* and *Serious Violence Duty* (Home Office, 2022b), victim support services can proactively ensure these agencies are aware of the breadth of services they offer, especially for victim-survivors with additional support needs, thus enabling more consistent referrals;
- Increase the number of specialist ISVAs in health and social care settings.
  - The continued presence of a known sexual violence perpetrator within a care setting is likely to result in many more victims. Victim-survivors who come forward from these settings must be allocated an ISVA who is

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trained to support them and has sufficient time allocated to enable multiagency working to maximise outcomes in the CJS to enable more known perpetrators to be barred from care settings (more on ISVAs in 5.4).

## **5.2 Inclusive service design**

Respondents were asked to imagine an inclusive victim support service. They stressed the importance of first impressions. Disabled victim-survivors described accessibility and aesthetics of their ideal setting and what would make them feel welcome. The quotes in Box 2 illustrate how some of them imagined that first contact and Figure 5 captures some of these ideas on a mood board.

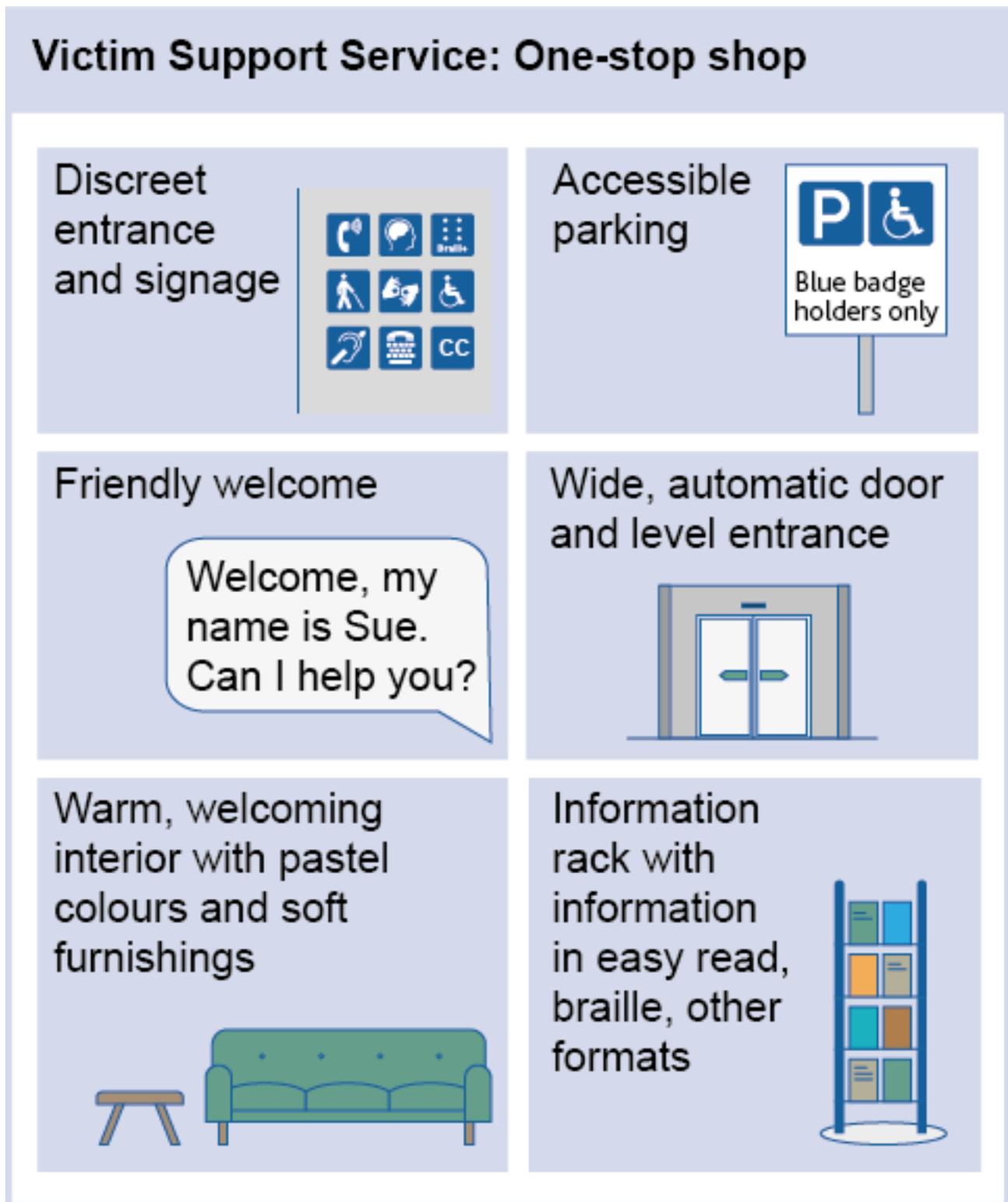
Respondents recommended a range of ways to make services easier to use by providing different means of access. For example, Grace wanted information to be available in a range of different versions, including

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spoken word and easy read and internet pages that are screen reader friendly. Nancy described level access, easy to access parking and public transport options. Francesca noted that having somebody to meet her outside the building would be helpful. Hazel found it difficult to travel to the sexual violence support service, but she liked the building where she had previously met her hate crime support worker, as it was centrally located near a bus stop and Hazel knew how to get there. The sexual violence support worker therefore met Hazel within the hate crime service.

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**Figure 5: “A warm welcome” mood board**



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## Victim Support Service: One-stop shop

Accessible toilet



Tea, coffee and biscuits in the waiting area



Wall signs



Ask us about our home visits and Zoom calls

We don't judge, we listen



We have all the time you need

Our 24/7 emergency telephone/text line is: XXX



## **Box 2: A warm welcome to an inclusive service**

The building is rather discreet. It's not obvious what it is there for. The counsellor would meet me at the door and then we'd walk to the counselling rooms together. (Bea)

The door is the first thing, an automatic door that's not hard to open. It has to be automatic, welcoming when you walk through, and someone's on hand at a reception desk, looking at the door, "Hello, welcome. Can I help you?" That makes all the difference. I've walked out a couple of times when I couldn't even find the door handle (laughs). You feel embarrassed. [...] Tea and coffee and water available where people are waiting. (Nancy)

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I think it would be more quiet. Not low energy but mild energy. The colour scheme is really important. Because when I walked into a lot of places it looked really clinical. Just like pastel blue or something might make it look a bit more calming and a lot less like jarring when you walk in. They had really good signage. (August)

They are able to properly control the lighting. What's particularly bad for me and a lot of other visually impaired people is strip lighting that kind of buzzes and it flickers. (Sarah)

A welcome message: "Welcome to xyz, where we are going to listen to everything you say and not judge. You can tell us everything that you need to in your own words, and we will sit here and listen and try and help you". (Sylvia)

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She specialises in working with victims of rape and sexual assault and also had experience of working with disabled people; and the two together in my head just went: “Oh, you might actually get it! You might actually be the person where I don’t have to justify every little aspect of my life.” (Olivia)

If it was a service that covered everything, so mental health as well as understanding honour-based violence or forced marriage, having all that in one place would be amazing. [...] Because I’ve always been made to feel that the lived experiences I’ve had are so out there. (Fatimah)

August, who identified as D/deaf, commented upon the need for more inclusive visors and face masks, such as ones where you can still see the lips. Lesley suggested the need to consider background noise and ensuring access to BSL interpreters and Braille. Her “ideal” support service would have childcare available

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to give parents time to talk freely. She also suggested that services need to employ a diverse staff team:

“Ideally having a diverse range of staff where clients can see themselves in the staff members. If it’s a service full of white women they’re probably going to go, ‘Oh, I don’t see myself represented here.’”

Grace reflected upon their identity as both disabled and non-binary. They add that services need to be informed about and able to respond appropriately to all aspects of diversity:

“I want someone who’s not going to make a big deal over [it] if I ask to use the they/them pronouns and over the fact that because I was using she/her back then I’ll end up using she/her to describe me at those points. [and] I want someone who can leave the disablism at the door. I don’t want to be in a room with somebody

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that treats the fact that I have impairments as some sort of tragedy... and not treat me like some weird object of pity and not speak extra loud.”

Respondents wanted services to be accepting of the fact that they may express trauma differently. For example, some neuro-diverse respondents laughed when recalling uncomfortable events. They wanted services to respond with the same sensitivity and compassion as they would for any other client.

Following several failed attempts to access appropriate support, Olivia accessed private counselling. Accessibility was highlighted on the counsellor’s website who also advertised that she had worked with disabled people and victim-survivors of sexual violence. This reassured Olivia that the service would meet her needs. (See Appendix G.) August said that knowing different access options are available helps to reassure her that a service was

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designed with disabled people in mind. Several respondents felt that providers should offer options to make services accessible rather than getting too focused on impairments and diagnosis, which is also recommended by Disabled Survivor's Unite (2021) and reflected in the Stay Safe East (2020) risk assessment.

### **Conclusion: Respondent's key expectations and specific recommendations**

Rather than expecting the victim-survivor to manage their impairment effects to become able to fit into a service, the responsibility for ensuring service access lies with the service provider. Disabled victim-survivors wanted to see upfront accessibility information for sexual violence support services to enable them to prepare for their first contact, but also because this can offer reassurance that the service was designed with disability in mind. All buildings that are to be used by victim-survivors must conform to

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Part M (Volume 2) of the building regulations, which set out minimum standards of access for buildings other than dwellings (Department for Levelling Up, Housing and Communities, 2015). Not only physical and communication support were considered important for services to create a safe and accessible environment. Other factors mentioned included disability equality skills, training and experience in staff, including receptionists. Respondents wanted services to understand that each victim-survivor expresses trauma differently.

### **Recommendations:**

- Development of a best practice checklist for assessing the accessibility of sexual violence support services. This should require services to
  - provide upfront accessibility information;
  - ask all victim-survivors about access needs upfront and ensure this information is shared between relevant agencies;

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- In-depth disability equality skills training for all staff, including receptionists; and
- Flexible funding for structural changes to the built environment to enhance accessibility and for the development of information about services in accessible formats.

### 5.3 Flexibility and making time

“For someone like me who has chronic illnesses, I can wake up one day and not be able to move. So having flexibility is an access issue. [...] My ISVA made sure to always book somewhere nearby in a place that was accessible or that had a lift. And then we had a few phone calls when I was stuck in bed.” (Quinn)

Many respondents had a strong preference for online or face-to-face support. Remote services introduced in response to Covid-19 had increased accessibility for most but not all respondents. Zoom was not

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appropriate for Paula who had a speech impairment. Hazel received both face-to-face and telephone support, but she preferred face-to-face. Sarah had a strong preference for remote support, as she was clinically vulnerable. Gina had moved to a new home following the sexual violence. She was protective of her new, safe environment and did not want to speak about her past in the new home. She therefore disengaged with counselling during the pandemic, as this was only offered remotely. Gina is one of the respondents who was interviewed face-to-face as a reasonable accommodation. Janet found that video communication can work, but only where face-to-face provision is not available. She was cautious of telephone support:

“It can just sound so patronising over the phone. Whereas face-to-face you can see somebody nodding, you can see they’re listening, and when

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they say you're doing great, you can actually see that person means I am doing great.”

The need for choice and for the survivors to take charge of interactions was also reflected during research interviews. One respondent chose to be interviewed via Zoom with her camera off, as she had a fear of cameras, which was linked to her sexual violence experience. The interviewer kept her camera on throughout. Unexpectedly, the respondent asked for the opportunity to put her camera on after the interview, once recording had stopped, to show the interviewer that she was “finishing with a smile”. This case illustrates that meeting the victim-survivor where they feel comfortable can help build trust.

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Trust was a common theme. Many respondents described realisation<sup>13</sup> occurring when they were able to talk to trusted individuals about their experiences. Trusted individuals were most often friends, family, GPs and helpline workers. Julie went to her GP practice when she was not coping after a relationship breakdown. She was seen by a mental health practitioner who listened and whom she could trust:

“I’m glad he kept pressing because then I started to talk about how the relationship with my abuser had been functioning and it wasn’t until it was coming out of my mouth in front of that healthcare professional that I was like, actually, this isn’t good, this isn’t normal, that’s not behaviour I should’ve been accepting.”

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<sup>13</sup> For many of the respondents realisation happened sometime after they had experienced sexual violence. By realisation we mean the process by which a victim-survivor begins to label an intrusive sexual experience as “sexual violence”.

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For Tracey and Yvonne, access to services was about the nature of interactions with the support provider such as feeling less rushed and providing more support when needed. Some respondents struggled to open up and needed time to build this level of trust.

Many respondents critiqued long wait times for support services, during which most were left with no alternative support. This is an issue for all victim-survivors, but for disabled people this can be catastrophic, as they are more likely to experience social isolation (Macdonald et al., 2018), which limits access to informal support. Disabled people's social isolation has been further compounded by the Covid-19 pandemic (ONS, 2022). Some clinically vulnerable people, such as Sarah, remained in shielding after Covid-19 restrictions have eased.

Quinn attended a creative support group whilst on the waitlist for counselling:

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“I went to this creative writing group for survivors. And it was so amazing. We didn’t talk about what had happened to us, we just had random prompts and they were really strange. And I’m not someone who’s really good with that random thing usually but for some reason it just worked for me.” (Quinn)

Quinn was keen for this type of support to be made available more widely. This was echoed by Fatimah, who made another suggestion on support to fill wait time:

“We may have a waiting list for talking therapy but in the meantime first teach you about coping strategies, so when you’re feeling anxious you can try X, Y and Z. I think things like that should always be going on. I think people don’t understand how amazing it is to build up a toolbox of things for you.”

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The way support is delivered can increase disabled people's trust for an organisation and service. Many respondents mentioned the value of small gestures, such as sitting down with someone over a cup of tea and getting to know them. Lesley reflected on the difference it made when her advocate came to police interviews with her:

“It might not seem massive but being able to go and sit in the café opposite the police station afterwards actually does mean a lot. Having my advocate come with me and genuinely be available and knowing that's protected time really helped.”

**Figure 6: “I need more time...”**



One respondent accessed 18 counselling sessions with a victim support service. The counsellor realised that this was not enough, but she could not offer more. The victim-survivor needed longer, because

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sometimes she needed the counsellor to repeat things to her and also because she had experienced multiple repeat incidents by multiple perpetrators, which took her longer to work through. This respondent had to continue her healing journey with a private therapist. Several respondents found victim support services inaccessible, but were able to pay for a more accessible private counsellor (see Appendix F for Olivia and Sean). These respondents recognised that this was a privileged position to be in. A few respondents received extensive support within victim support services that was free of charge, but this was the exception. Janet saw the counsellor within her local sexual violence team weekly for ten months:

“It should have finished quite a bit before that, but he kept going back to his manager and explaining I needed a bit longer, so it kept getting extended. [...] It kept going on for ten months. I did feel ready at the end of the ten months.”

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Janet was grateful to have received support for this long, but it is also important to note how precarious this was, as there was always the risk that it would be terminated.

### **Conclusion: Respondent's key expectations and specific recommendations**

Some disabled victim-survivors needed additional time with their advocate or counsellor to enable their needs to be met. They asked for the flexibility to be able to choose between online and face-to-face support and helpline support that is available out of working hours. Respondents recalled feeling lonely during long wait times for victim support counselling and emphasised the importance of having someone to talk to about their sexual violence experiences who could respond appropriately. Some gave excellent feedback about creative support groups offered to them during wait list times.

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## **Recommendations:**

- Flexible funding to enable flexibility in service delivery to allow additional needs to be met (e.g. extra time, online and face-to-face support alternatives, creative solutions to help fill wait times).

## **5.4 ISVAs and advocates**

ISVAs can provide emotional and practical support and they are required to tailor support to the needs of their clients (Home Office 2017). As such, they are ideally placed to work with disabled victims-survivors. Several respondents who did not have an advocate or ISVA described the types of support that an advocate or ISVA could offer as their “ideal service”. For instance, following her police interview Inga would have appreciated:

“somebody to sit down with me and find out how I’m feeling, what I need at that time. And

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somebody to support me who knows the legal system and knows what the next step is, what I can ask, what I can appeal against.”

Kate described how lonely her journey was when reporting to the police, going to hospital for a physical examination and awaiting her CPS decisions. She would have liked someone to help normalise her experiences. Julie received ISVA support remotely via the phone during the first UK Covid-19 lockdown, but in her memory this support blurred with that given by the police and victim support. Over the phone Julie was unable to build a personal connection with her ISVA. She felt unable to admit that she “wasn’t coping”:

“I had a couple of people calling me regarding how I was doing about the case. [...] I always felt like I wasn’t quite saying the right thing, I don’t even know what the right thing would’ve been, because basically they were just checking in with

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me to see how I was coping, but I guess it just felt like I wasn't coping.”

Remote working was new to most services during the first UK lockdown in 2020, but it is important to learn from experiences of victim-survivors like Julie about the limitations of remote communication. If this was to become the only option again in the future, services should have means of checking whether their support is working for their clients and be prepared to explore alternatives. For instance, Julie, who was engaged during her Zoom interview, may have found it easier to form a connection with her ISVA via video call.

Timing of access to the ISVA was also vital and for several respondents inadequacies here can be linked to the police not meeting its obligations outlined by the Victims' Code (MoJ 2021b). Rose was told about ISVAs upon her third contact with the police. By the time Rose saw her ISVA two weeks later her case had been closed: “I think it would have been much more

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helpful if it had been at the time that I was going through the police process, rather than just a bit of a catch up afterwards.”

Yvonne asserted that her ISVA saved her life when the police were letting her husband return home after questioning: “My ISVA told me that I could oppose entry. And if I hadn’t opposed entry, I seriously don’t think that I would be here today.” She also recognised the value of this support in helping her to move forwards from her experiences. Lucy’s ISVA offered ongoing practical support throughout her court case and for six months beyond. Lucy felt that others treated her at times “like a stupid person”, but her ISVA would challenge this right away. For instance, when Lucy was too unwell to do this for herself, the ISVA rang the GP to make an appointment to discuss Lucy’s mental health and she attended the appointment. The consultation went so badly that the ISVA encouraged Lucy to put in a formal complaint

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about D/deaf discrimination. The GP surgery subsequently ran D/deaf inclusive communication skills training. Lucy's next consultation with a practitioner who had attended this training went exceptionally well. Lucy was now able to access the healthcare she needed to address post-traumatic stress disorder (PTSD) triggered by the sexual violence.

Despite the registered intermediary scheme supporting 500 individuals per month (MoJ, 2022), only one respondent stated they had accessed an intermediary. It is likely that some of the other respondents had accessed intermediaries and that they did not recall this. In describing her ideal victim support service, Julie described intermediary support to the letter. She needed support with pinning down the timeline of events that lead to sexual violence, and she would have benefitted from knowing the "kind of

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questions that they were going to ask” in advance and from help with understanding the processes:

“Quite often I think, neurodivergent or disabled people just need another run up at something. Rather than just being like: ‘Here’s the barrier, smack you in the face’; like: ‘Here’s what the barrier’s going to look like, here’s where it’s going to be, these are the things that you need to do in order to meet that effectively”. (Julie)

Julie described that the police made assumptions about her capabilities as a victim-survivor who comes across as highly articulate, even though she disclosed neurodivergence. Paula’s experience with the police and CPS was mostly negative (see Appendix I), but she gave excellent feedback on her intermediary support. A relative who supported Paula during the research interview described that the process was well explained. The intermediary came prepared with communication boards that had options based on the

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statements that had already been given by Paula's relatives:

“We said that the questions needed to be as closed as possible and I think they did a really good job because they spent a lot of time planning how they were going to get Paula's statement in the right way knowing how she communicates.”

It took three months to organise Paula's police interview with the intermediary. Paula struggled with recalling detail after this time, and this contributed to the case being closed. This long wait supports the thesis that there is a shortfall of intermediaries.

Nonetheless, ISVAs and advocates are in an ideal position to make timely referrals.

A small number of respondents had accessed '*by* and *for*' advocacy services. Lesley explained that “people don't recover if their basic needs aren't met” and that

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by and for services are more likely to be able to address wider needs, as opposed to signposting. Advocacy support described by Osma and Blessing was holistic, long-term and flexible:

“They help me deal with what’s going on in my life. If I need to go to the police station or whoever I need to talk to or if I need additional support, they can provide all that. Every week my advocate checks up on me, see how I’m doing.”  
(Osma)

Blessing explained that her advocate in a by and for service is always “just a phone call away”, whilst her community psychiatric nurse is not always available. Osma and Blessing highlighted the importance of consistent out of hours support provided by one organisation that takes a holistic approach to working with victim-survivors. By and for services offer more intense and longer-term support due to smaller client

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numbers, enabling the advocate to “truly understand your case and there isn’t a time limit”.

### **Conclusion: Respondent’s key expectations and specific recommendations**

Specialist victim support advocates and ISVAs are part of the solution when they are allocated at the right time and have the time and resources to offer long-term support that is responsive to the victim-survivor’s support needs, in accordance with the Enhanced Rights as outlined in the Code of Practice for Victims (MoJ, 2021b). They must be on offer to all disabled victim-survivors, including those who have experienced sexual violence in care settings.

Only one respondent recalled using an intermediary. Several had struggled with communication difficulties that could have been mediated by such support and this often resulted in cases being discontinued. “Police officers have a responsibility to identify that there is a difficulty communicating directly with a witness” (CPS,

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2021). ISVAs and advocates can play a vital role in advocating for these responsibilities to be met.

### **Recommendations:**

- Sharing of good practice examples to enable learning across the sector, for instance via regional events;
- Provide sufficient and sustainable funding to increase the number of specialist ISVAs with reduced caseloads;
- ISVAs and advocates must advocate for the involvement of justice intermediaries where this would be beneficial. They should advise a client to appeal if communication needs have not been met.

## **5.5 Peer support and ‘by and for’ support**

More than half the respondents had a strong preference for being supported by other disabled people within peer support groups and one to one

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interactions. Nancy's ideal service would operate within a disabled persons' organisation. Other respondents were cautious about victim support being offered within disabled people's organisations. Lucy wanted a D/deaf sexual violence victim support service, but not a generic D/deaf service that also offers victim support:

“Survivors of sexual violence need a dedicated service. It would be a bit weird if you go in and someone's like: ‘I need you to ring the doctor's about my headache,’ and someone next to them is crying because they've just been raped.”

Although some respondents had positive experiences of specialist services,<sup>14</sup> only a few respondents explicitly asked for these. The few respondents who

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<sup>14</sup> Specialist services hold knowledge about how best to work with specific impairment groups (usually people with learning disabilities and/or autism), but usually staff are not members of the group they are supporting. In addition, there are a small number of specialist ISVAs.

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asked for specialist services were neurodiverse.

Some asked for pan-impairment by and for services.<sup>15</sup>

Most wanted all victim support services to become better equipped at working with disabled victim-survivors. For Tara this was about choice within existing services. Yvonne reflected on the human qualities she expects of a support worker:

“Someone who is trauma informed, highly up to date autistic training, maybe even be autistic, that would be good, wouldn't it? Then I'd have someone I could relate to without having to try and check out that we were understanding each other.”

Moments of relating to each other's shared experiences happened in several of the interviews that were conducted by disabled interviewers. For

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<sup>15</sup> This means by and for services by disabled victim-survivors for disabled victim-survivors that do not focus on a single impairment group.

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instance, below is an exchange between a neurodiverse interviewer and respondent:

Interviewer: I don't know if you find this, but I feel like the webcam is a giant eyeball and it's almost worse than normal eyeballs (laughs).

August: I find that I flicker between the webcam, which is like its own eye, but then also the eyes of the people that are on the screen, including myself (both laugh).

Quinn explained their preference for a disabled victim support worker by stating that “there's a lot of macroaggressions there that can really fly past somebody if they haven't experienced it directly”.

Francesca asserted: “A disabled person's organisation would be so helpful, just because it's another layer, these people understand what I've

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gone through.” Sylvia stated: “I find it easier to talk to disabled people and open up, because I don’t feel like I’m going to be judged so much.” When imagining her ideal victim support group, she stated that “a group with all disabled people – or even four, five disabled people would make me feel an awful lot more comfortable.” Gina’s peer support group offered a “safe space” to be around “other women who had similar experiences”. The topic of conversation was broad “it wasn’t that we had to sit there and talk about why we were all there, we all knew why we were there. But just realising you’re not the only one”.

Below is an example of peer support observed during a focus group:

Lilly: Married. Married. Yeah. When I start to get married – So he make the baby for me and then he used me for passport. And that’s – I told them that he raped me. Tried to take

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naked picture of me in the bath and I didn't like it.

Queenie: I have experienced that as well, of rape, but not as what she done. But if that person, if they take naked pictures of you, they can't do that, they have to ask you for your consent and that. I think her situation, her husband's not asked her for consent. If Lilly says no, she don't have to do it.

Queenie validated what Lilly said, agreeing that the perpetrator's actions were wrong and provided legal language to justify this. This is an interaction between two women with learning disabilities, but this could also be possible within a fully inclusive peer support group, which takes time and care to listen to each group member. (Appendix I contains more examples of peer support within this focus group).

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For a peer support group to become fully inclusive it would need to run differently to how many peer support groups are currently run. For many disabled victim-survivors, groups work better if they are smaller. Bea stated that to be able to lip read a group should be no more than six people. The way in which group members are positioned, lighting and the size of the room are important factors that impact on her ability to communicate effectively. Some disabled victim-survivors need longer to settle into a peer group and to feel safe to speak out. Tracey was part of a longer-term group, which operates at a different pace to usual victim support groups. She reported that attending a group that accommodates her need to take extra time had paid off:

“Although I’ve got problems with being shy at first and not speaking up properly, once I’m in a group, like I’ve been with these guys..., I spoke out a bit more and I’m not so shy anymore.”

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There was much enthusiasm amongst respondents for helping other victims-survivors. Lucy recently qualified as an ISVA. Several of the other respondents were working as peer supporters in some capacity and used their experiences to inform this. Olivia reflected on working with victim-survivors:

“If she’s quite distant and doesn’t really want to engage, that’s okay, because I was that lady that was just pushing everybody away. [...] I will turn up at the same time each week and if you turn up and you’re quiet that’s fine.”

Fatimah worked in a women’s support service. Having lost contact with her family in the aftermath of honour-based violence, she understood how lonely some of the women felt. Fatimah’s personal experiences have helped her become a sensitive support worker.

Thomas reflected on his motivations for offering peer support and the benefits to him: “I said: ‘I’ve got to give back, I’ve got to stop this and just make a

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difference.’ [...] My mental health has been made stronger by being stimulated into such a thing.” Noor stated that “support services should make it easier for survivors like me to be in these roles and think ‘someone like me can do this’”. She believed that mentors and training programmes could help her to become a peer counsellor.

### **Conclusion: Respondent’s key expectations and specific recommendations**

About half of the respondents had a strong preference for being supported by another disabled person within victim support services. There are currently only a small number of services run by and for disabled victim-survivors. Some disabled victim-survivors who participated in this research reported better outcomes when they were supported by another disabled person, such as feeling more relaxed and feeling that they belonged within a service. Many respondents were enthusiastic about helping other victims-

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survivors or to input into the design of their local services. Respondents also highlighted the need to consider the size of peer support groups and room set up.

### **Recommendations:**

- Work in partnership with disabled victim-survivors and their organisations or networks on implementing the recommendations found in this report;
- Flexible funding to enable flexibility in service delivery (e.g. smaller and/or longer peer support groups, adapt room layouts to meet needs);
- Offer mentoring and training programmes for disabled victim-survivors to become peer supporters, including within or attached to

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support services with some caveats to keep people safe and prevent further harm;<sup>16</sup>

- Seed fund and enable the development of more **by** and **for** services.

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<sup>16</sup> For a victim-survivor to be able to undertake training as a support worker/counsellor there has to be a time lapse between experiencing victimisation and supporting others. Experiencing trauma and then working with people who have experienced trauma can pose risks to both parties and cause further harms.

## 6. Conclusion

This research was conducted to a tight timeline. The report findings are not generalisable to all victim-survivors but relate to the experiences of respondents who took part in this research. Despite considerable recruitment efforts, there were only two respondents from Wales, three male respondents and one D/deaf BSL user. Some ethnic minority communities were underrepresented. Disabled people living in communal establishments, such as supported living accommodation, were less likely to notice recruitment posts via victim support services. Nonetheless, Appendix B highlights the considerable efforts that have been put into participant recruitment and Appendix C demonstrates that this resulted in much diversity amongst the sample, for instance in terms of region, age and experience with the CJS. It is recommended that MoJ commissions further

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qualitative research that is conducted in partnership with underrepresented groups of disabled victim-survivors, including **(1)** victims-survivors from Wales, **(2)** males, **(3)** D/deaf BSL users, **(4)** ethnic minority communities and **(5)** to explore victim support needs of users within health and social care settings.

These limitations aside this report makes a strong original contribution. This qualitative research was the first to give voice to the lived experiences of disabled victim-survivors of sexual violence in England and Wales who have attempted to access (or not) victim support services. Respondents provided rich and detailed information about their past experiences and aspirations for future service design. The report captures many of the challenges experienced by disabled victim-survivors when attempting to access support services, as well as examples of good practice.

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Findings and recommendations from this research should be of interest to those who commission and deliver services that support victim-survivors of sexual violence along their journey towards accessing justice and support them to cope and recover, which includes PCCs. They should be considered by those who work on the Serious Violence Duty, which requires “relevant services work together to share information and allow them to target their interventions, where possible through existing partnership structures, collaborate and plan to prevent and reduce serious violence within their local communities” (Home Office, 2022b, p.7).

The headings below summarise the key expectations of disabled victim-survivors who participated in this research, in terms of what they wanted from victim support services and what they considered to be effective in helping them engage with the criminal justice process and cope and recover from the crime:

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- I. Ensure there are the right pathways into victim support services through effective referrals and liaison with agencies who are required to deliver the *Code of Practice* (MoJ, 2021b), *ACPO-CPS (2015) Protocol* and *Serious Violence Duty* (Home Office, 2022b).
- II. Victim-survivors want to be asked by about access needs upfront, when they first approach a sexual violence support service. If victim-survivors access services by referral, any information about access needs must be handed over.
- III. Design inclusive services that are accessible to all, with the aid of a best practice toolkit and flexible funding and by delivering disability equality skills training.
- IV. The victim-survivor should be at the centre of service design and delivery.

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- V.** Work in partnership with disabled victim-survivors and their organisations and networks on service design and delivery.

These key expectations and recommendations map against the National Statement of Expectations for commissioning Violence Against Women and Girls services<sup>17</sup> (NSE - Home Office, 2022a). This helps to contextualise them within the guidance that is already used by commissioners and to add further justifications for some of the NSE standards. For instance, key expectation nr. **(III)** inclusive service design and **(IV)** the victim-survivor at the centre of service delivery map onto key expectation nr.1 in the NSE. Moreover, some of the recommendations in this report reiterate or expand on recommendations from

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<sup>17</sup> The Tackling Violence Against Women and Girls Strategy (Home Office, 2021) includes a commitment to supporting male victims of crimes that disproportionately affect women and girls, including sexual violence (HM Government, 2022).

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the NSE. This includes the assertion that online mechanisms are not a substitute for face-to-face provision and the suggestion to ensure that more specialist ISVAs need to be made available, including in health and social care settings.

Recommendations found in this report are aimed at informing future victim support service commissioning to enable more services to get it right for disabled victim-survivors every time. This can only happen if local services have the right support through commissioning and policy guidance (e.g., a toolkit for driving change). Moreover, by working more closely with local disabled people and disabled people's organisations, sexual violence support services can ensure that they are prepared to meet the needs of local disabled people.

Figure 7 overleaf provides an overview of the recommendations made within this research report. It starts by putting the victim-survivor at the centre of

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service design and delivery through flexibility in service delivery. It then moves from the individual to local service delivery, to local commissioning and then to central government. Recommendations relating to the development of more by and for services are illustrated as shared by local commissioners and central government. The figure exemplifies the interplay between central decision making and local service delivery. It highlights the need for strong leadership, but also the need for flexibility on the ground. Moreover, Figure 7 shows how decision-making at policy and commissioning level can impact on the lived experiences of disabled victim-survivors of sexual violence accessing services.

**Figure 7: Overview of Key Recommendations**



## **Guidance for commissioners**

- Encourage the sharing of good practice examples to enable learning across services, for instance via regional events;
- Resource liaison work with police and other key agencies (GPs, social services);
- Encourage the recruitment of a more diverse staff team;
- Resource changes required to enhance accessibility;
- Increase the number of specialist ISVAs with reduced caseloads, including within care settings.

## **Enable the development of by and for services**

- Map local by and for services and local capacity to develop new services;
- Seed fund the development of new by and for services;
- Resource these services to offer longer-term support to reduced caseloads.

### **Toolkit for driving change**

- Checklist for assessing accessibility in victim support services, incl. upfront accessibility information and upfront needs assessments;
- Services to self-monitor engagement with anti-discriminatory practice;
- Strengthening of liaison work, incl. with justice intermediaries.

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## **Appendix A**

### **Ethical Considerations**

In recommissioning the Rape and Sexual Abuse Support Fund, the Ministry of Justice wanted to take account of the experiences and expressed needs of disabled victim-survivors of rape and sexual violence. The objective was to inform the commissioning of services to help ensure that they are better able to respond to these needs. The British Sociological Association (2017) Statement for ethical practice stipulates that considerations for the ‘greater good’ should never outweigh the rights of the individual. Even though there were ethical motivations for conducting the research, the primary concern was to safeguard those it involved.

This research engaged a “vulnerable” respondent group about a sensitive topic and this raised several ethical challenges. The research team were aware of

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these challenges and were also experienced in successfully addressing similar challenges in past projects. This project adhered to the Leeds University ethics and safeguarding policies, the British Sociological Association (2017) Statement for ethical practice and to the Ethical principles in the Government Social Research (2021) Professional Guidance.

Information about the study was provided in accessible formats to enable respondents to make an informed decision about research participation.

Information explained the purposes of the study, risks and benefits of taking part, the possible future use of the research findings and compliance with the UK-GDPR. Respondents were informed how far they could be afforded anonymity and confidentiality. All names used are pseudonyms. In some cases, pseudonyms were used that did not reflect the respondent's ethnicity to preserve anonymity. Care

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was taken in presenting case studies, in that these did not present highly identifying information. Some data was detached from the respondent's usual pseudonyms to ensure the respondent could not be identified.

Support was put in place in case the sensitive nature of the research did cause distress. Prior to their interview each respondent was provided with contact information for their local victim support services. Where local services did not have the access needed, Stay Safe East offered to provide post interview support remotely. When conducting interviews remotely, precautions were taken to ensure that the person was alone and not overheard.

The researchers ensured that the physical, social and psychological well-being of respondents was not adversely affected by the research. This included minimising risk of re-traumatisation of disabled victim-survivors, firstly by only using interviewers who were

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experienced in talking to disabled victim-survivors in their roles as advocates or researchers and second by asking questions about “What happened next?”, rather than “What was done to you?” Thus, respondents were invited to focus on services responses and their help seeking, rather than on recounting their sexual violence experiences.

Three key positions were communicated to respondents throughout their interview: the social model of disability and the stance that personal characteristics (such as age, gender, sexual orientation, gender identity, ethnicity and impairment) and behaviours displayed by a victim-survivor are never contributing factors to sexual violence. The full responsibility for sexual violence lies with the perpetrator. Moreover, researchers really listened. They acknowledged that they believed their interviewee, as demonstrated in the extract below:

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Carly: Ultimately I wanted to be acknowledged, to be, you know, recognised what I went through to be heard and to feel some sort of validation, which I don't feel anything, other than pushback. I feel denied, dismissed, ignored, disbelieved, almost like punished over and over, re-traumatised, so I want the opposite of that.

Interviewer: Can I just say that I absolutely believe you. I've worked with survivors for a very long time. I absolutely believe you. And as one disabled woman to another I think it's important that we say that.

Being acknowledged in this way contributed to the creation of safe spaces. During debrief many respondents asserted that they had enjoyed

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participating and that they felt this was morally the right thing to do. For instance, Olivia explained:

“However upset I get I said to myself I’m going to do this because unless people come forward and share their stories change won’t happen.”

## **Appendix B**

### **Advertising and participant recruitment**

#### **Advertising via the project Twitter account**

The research team created a Twitter account to help with recruitment and to share progress updates. The Twitter account gained followers quickly by following relevant support organisations and agencies. The second author of this report managed the Twitter account closely and monitored the accounts that were following and were being followed.

Tweets were used to share updates regarding the research progress and to advertise to potential participants about the research. All Tweets were agreed by MoJ's social media/communication team before being tweeted to ensure that they met with standards.

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The Twitter account was an opportunity to connect with audiences who might not typically be accessed through organisational mailing lists or might not be individually known by gatekeepers. It was also a good platform for advertising and updating about the project concisely. Word limits for each Tweet encouraged the research team to be clear and forthright with the key messages. This type of dialogue might have been more attractive to potential participants to enquire about the research than some of the longer and more detailed descriptions.

## **Proactive networking with gatekeepers**

The research team interacted with over 50 victim support and disability organisations from across their networks (outlined in box 3) and beyond these.

(Roughly two thirds of the organisations approached were victim support; one third were disability organisations.) In most cases this involved initially making contact via e-mail to outline the study and

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meeting with service managers to explain the research further. Around half of the organisations responded when they were first approached. Others required more persistent prompting. The final page of this appendix features the information sheet, which was sent to organisations and was the basis of initial discussions. Most of the organisations offered to help, either by advertising the study via their websites, newsletter, Twitter and Facebook pages. Others offered to speak to eligible clients about the project and to encourage them to contact the research team if they were interested in participating. Some did both.

Some organisations made a prodigious effort to advertise the study and to support respondents to take part, for instance by offering aftercare. The Survivor's Trust advertised the study multiple times, using multiple formats. They helped to reach out to member organisations within their networks that worked with groups who had thus far been under

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recruited. Two organisations arranged focus groups with pre-existing groups of female victim-survivors with learning disabilities and/or autism. The research team had hoped to also conduct a focus group with males and one with victim-survivors from Wales.

Several options had been discussed with several gatekeepers, at times extensively, but none of these were possible to conduct within the tight timescale of the research.

### **Box 3: Networks of disability and victim support organisations**

Ministry of Justice facilitated contact with partner organisations from within the Rape Review Roundtable and further victim support organisations commissioned by the *Rape and Sexual Abuse Support Fund* (MoJ, 2019).

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The Centre for Disability Studies (CDS) at the University of Leeds and the Centre for Culture and Disability Studies (CCDS) at Liverpool Hope University have connections to disabled people's organisations across the UK, regularly working and consulting with organisations such as Disability Rights UK, Inclusion London, Sisters of Frida, Speakup and various other self-advocacy organisations of people with learning disabilities. The second author of this report is lead coordinator of the Disability Hate Crime Network and a steering group member of the British Society of Criminology Hate Crime Network.

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Stay Safe East (SSE) is a partner in the London Victim and Witness service led by Victim Support and the Violence against Women and Girls (VAWG) Ascent partnership led by Solace Women's Aid. The SSE advisory group on violence against disabled women brings together disabled women, their organisations and other experts in the VAWG field. In addition, D/deaf networks were accessed via SignHealth.

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## **Call for participants: Qualitative research to understand the support needs of disabled rape-victim survivors**

The Ministry of Justice is funding qualitative research to inform the recommissioning of their Rape and Sexual Abuse Support Fund.

We would like to know about disabled people's experiences of trying to get support, or why they did not access support after rape or sexual violence. Did that support work for them? Did it meet their access needs? If they reported to the police or went to court, what happened? We also would like to hear their thoughts about what they would want from a support service.

### **Why are we approaching service providers?**

This being such a sensitive topic, potential participants are more likely to approach us, if they have heard about the research from someone they trust. This is especially true for the most marginalised

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groups of disabled people. Please help us by making eligible clients aware of the research and please do not hesitate to contact us to discuss any concerns you may have about the study to help you decide whether it would be appropriate to approach your clients.

### **Who is doing the research?**

We are a team of disabled and non-disabled researchers who are passionate about ending violence against disabled people. All of us have experience of working or doing research with disabled victim-survivors. We work for the University of Leeds, Liverpool Hope University, Stay Safe East (a user led service for disabled victim-survivors) and SignHealth (a user-led service for D/deaf victim-survivors).

### **What are we asking participants to do?**

We are asking disabled adult rape and sexual violence victim-survivors to participate in interviews OR focus groups in April 2022 online on Zoom. If a person prefers this, we will try to meet them face-to-

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face. We will meet their access and communication needs. To say thank you for giving up their time, we will compensate them with a £30 Amazon voucher.

### **Who can participate?**

We want to talk to disabled adults from across England and Wales who have experienced rape or sexual violence in adulthood (age 16+). We are sorry, but we cannot include those with an active criminal justice case.

We adopt the definition of disability from the Equality Act 2010. Disabled victim-survivors are those who have a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities. This includes physical or sensory disabilities, learning disabilities, neurodiversity and long-term mental health conditions with onset prior to the sexual assault.

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## **What support do we offer during and after the interview?**

The interviews do not focus on personal experiences of rape or sexual violence. We want to find out what happened next when individuals sought support (or not). However, by talking about their experiences of seeking support, respondents might become upset or angry. They can pause or stop the conversation at any time. We will be supportive and respect individual's wishes to end the interview.

At the start of each interview, we will give respondents contact details for support in their local area. If they feel the need to speak to someone about their experiences after the interview, one of the Stay Safe East counsellors will offer support in a one-off session on Zoom. They can help individuals think about their local support options.

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## **Where can I find out more?**

Please visit our website <https://survivors-project.leeds.ac.uk/> for more information, including a short video that introduces the project.

If you would like to discuss the research or require more information, then please ring the lead researcher Dr Andrea Hollomotz on XXX or email us at XXX

## Appendix C

### Respondent Demographics and other Characteristics

**Table 1: Respondent demographics (n=39)**

<b>Age group</b>	
18-24	2
25-34	14
35-49	11
50-64	11
65-79	1

<b>Employment status</b>	
Full-time	7
Part-time	5
Self-employed	2
Unemployed	21
Carer	1
In education	1

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<b>Gender identity</b>	
Male	3
Female	34
Trans	1
Non-binary	1

<b>Religion</b>	
Christian	17
Muslim	3
Jewish	1
Spiritual practice	1
No religion	17

<b>Ethnicity</b>	
White	29
African	1
Bangladeshi	2
Asian	3
Chinese	1
Traveller	1
Mixed-other	1
Pakistani	1

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<b>Sexual orientation</b>	
Straight	23
Lesbian	2
Gay	1
Bisexual	6
Queer	1
Asexual	2
Pansexual	1
Not reported	3

<b>Region</b>	
North West	4
North East	1
Yorks. & Humb.	1
West Midlands	5
East of England	2
London	9
South East	7
South West	8
South Wales	2

(Both focus groups took place in the south, which skews the regional demographics.)

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<b>Housing</b>	
Care home	1
Emergency Respite	1
Living with parents/family	4
Lodger	1
Mortgaged property	4
Owned outright	3
Rented property	9
Social housing	11
Supported Living	5

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**Table 2: Other respondent characteristics (n=39)**

	Yes	No
Accessed a sexual violence support service	34	5
Single incident of sexual violence	5	34
Reported adverse childhood experiences (including child sexual abuse)	10	29

<b>Reported sexual violence age 16+</b>	
Yes, to the police	18
Yes, to social services	2
Yes, to police and social services	7
No	12

<b>Stage reached with criminal justice process</b>	
I did not report the crime to the police	12
I did report to the police but have no knowledge of what happened next	5
I did report to the police but later decided not to continue with the criminal justice process	5
I reported to the police but it was no further actioned	9
My case is complete following a trial	2

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<b>Stage reached with criminal justice process</b>	
My case is complete following CPS decision	3
Other	3

<b>Type of sexual violence perpetrator age 16+ (primary incident discussed in interview)</b>	
Friend/acquaintance	5
Family member	2
Housemate	2
Spouse/partner	15
Paid carer	3
Gang/multiple perpetrators (at least 1 person known to the victim)	3
Stranger rape	3
Forced prostitution/sex slavery	2
Vague/did not make explicit	4

## **Appendix D**

### **Creative Methods**

Creative methods can provide alternative ways of making sense of, and articulating experiences. They can prompt respondents to process their understandings in different ways and then present these in a format that goes beyond the written word (Tarr et al, 2018). Creative methods are useful for opening up difficult conversations in a sensitive and supportive way (Rice and Mündel, 2018; Vaart et al, 2018). Respondents were given the option of using creative methods to revisit, piece together, and re-story their experiences in a safe, supportive, and collaborative environment (Burch, 2021b).

This research used a “snakes and ramps” board akin to the popular board game “snakes and ladders” to create a visual representation of the process of accessing and receiving support, and to encourage

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conversations about experiences at different points of this journey. It was created as respondents shared their journeys to accessing support, or not. The visual representation captured the “messiness” of this journey and highlighted both barriers (snakes) and opportunities (ramps). This helped to explore the timeframes of accessing support, how and why respondents chose to access support, barriers experienced and specific areas of improvement. (See Appendix F for an example.)

Creative methods offer an opportunity for further reflection but should not be enforced. It is important that a choice is provided for both the interviewer and respondent. Some of the interviewers did find these difficult to manage online via Zoom and some respondents opted not to use the board when offered, resulting in a third of respondents using it.

All respondents participated in the second creative method, the Miracle Question (De Shazer 2021). They

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imagined that they would wake up one morning and find that an accessible victim support service had opened in their local community. Respondents “walked” the interviewer through the service, detailing how they would access it, how they would be greeted, what the space would look and feel like, and how it would meet their access needs. This helped respondents to think about how an inclusive and accessible service might respond to some of the barriers to accessing support already identified.

## **Appendix E**

### **Coding and report writing**

All focus groups and interviews were audio recorded and transcribed following 'true verbatim' style. This enabled 'word-for-word' reproduction of the verbal data that reflected the voices of participants (Halcomb & Davidson, 2006). Coding was an iterative and collaborative process. The authors of this report accessed transcripts as they were made available and conducted their own preliminary readings of the data independently. As there was a bigger team of researchers conducting the interviews, these initial readings were useful to develop familiarity with interviews that were conducted by another researcher.

The primary team of researchers generated a loose and flexible coding framework to help organise the reading of data and shared this with one another. This was done both in conversation and through the use of

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the software analysis system, Nvivo. Coding categories were both inductively and thematically constructed (Braun and Clarke, 2006) in accordance to researcher's own interpretations and the research questions that were set by the Ministry of Justice. The coding framework included parent nodes and child nodes. Parent nodes represented a broader categorisation of a theme, for example "BARRIERS and negative experiences". Child nodes picked up on more specific interpretations or aspects of this theme, for example "barriers at point of access".

The third author of the report was a non-academic researcher who did not physically code within NVivo, as learning how to use this tool and finding ways of making this accessible would have required additional time that the project did not have. This made communication between the primary researchers even more essential throughout the coding process to avoid duplication of work and to ensure coherence within

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coding strategies. Codes were continually revised and reinterpreted as the team engaged with more data and had continued conversations with MoJ. In this way, the approach to coding data was not to develop tidy and rigid categories of analysis, but ‘unfinished’ categories, subject to ongoing interpretation (Mason, 2018).

All primary researchers contributed to the developing coding framework, which helped to visualise the whole dataset in accordance to the evolving coding categories. The primary researchers met in person for an analysis day and held several additional analysis meetings via Zoom. This allowed the team to discuss the coding categories in more detail, share any important details from individual transcripts, and begin to develop a structure for the full report. The first and second author shared the data that was initially sorted in NVivo in accessible word documents that were organised by nodes. This enabled all researchers to

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immerse themselves more fully in the data by reading and re-reading the data thematically during the writing of this report.

## **Codebook introduction**

The codebook overleaf displays four parent nodes:

- (I)** Victim support service types;
- (II)** SOLUTIONS, future suggestions, things that really helped;
- (III)** BARRIERS and bad experiences – things that put people off and
- (IV)** Police and CJS.

Each parent node contains between four and nine child nodes. The data was coded within these.

The files column in the codebook counts how many separate data files were linked to each node. There

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were 37 files in total.<sup>18</sup> The reference column counts how many times, across all the files linked to each node, the node was linked to.

Note that not all the data contained in the NVivo nodes could be used. Due to the focus of this report, especially the data in group (IV) was, for the most part, not included. Some data was linked into more than one node. For instance, a respondent who discussed support provided by their ISVA (included in parent node (I)) may have commented on ways in which the ISVA provided Choice & Flexibility (included in parent node (II)).

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<sup>18</sup> Each interview was a separate data file (n=30). For ease of coding focus group 1 was divided into six data files. Files 1-5 were narratives focussing mainly on just one respondent. File six was the discussion at the end, where the women dreamt up their ideal victim support service. This breakdown was not possible for focus group 2, which constituted just one file in NVivo. Overall, there were 35 files focusing on single case studies and two files of focus group discussions.

## Codebook

### (I) Victim support service types

This group broke down victim support services into types of services received. It included respondent's experiences of using these services (positive and negative), as well as their expectations in these services.

Name	Files	References	Description
ISVAs and advocates	21	73	Respondents discussed support provided by their ISVA or advocate.
Counselling and talking therapies	26	82	Respondents discussed their experiences of counselling and talking therapies.
Groups, peer support and arts classes	17	51	Respondents discussed their experiences of groups, peer support and arts classes.

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Name	Files	References	Description
Helplines	11	19	Respondents discussed their experiences of accessing helpline support.

### **(II) SOLUTIONS, future suggestions, things that really helped**

This group included positive experiences of respondents and their feedback on things that have worked for them when accessing victim support services with a focus on what helped them cope and recover from the crime. It also included their suggestions for service development, arising from reflections on negative experiences and responses to the “miracle question”.

Name	Files	References	Description
First person told	30	68	The first person whom a victim-survivor told about their experiences and their responses were crucial in enabling (or not) a person’s journey towards accessing support and the CJS. Due to

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Name	Files	References	Description
			the focus of this report on services (not on what happened before they tried to access them), only little of this data was used.
Disability equality informed and inclusive services	29	130	Victim-survivors spoke about experiences of accessing services where they felt included. Often, the person working with them was disability equality informed. Respondents also spoke about the “look and feel” of their ideal service.
Disability organisations and support from disabled peers	19	40	Respondents discussed their experiences of receiving victim support services from a ‘by and for’ disability organisation and/ or support offered by a disabled peer supporter. Data about respondents who worked in the role of peer supporter (or their aspirations to do so) were also included in this group.

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<b>Name</b>	<b>Files</b>	<b>References</b>	<b>Description</b>
Intersectionality	13	27	Disabled victim-survivors explained their needs arising from intersectionality and how and why these needed to be met by services thinking beyond disability.
Choice & Flexibility	19	64	This included respondent's accounts of being offered choice and flexibility in victim support services or their desires to be offered greater choice & flexibility, suggestions on how this could be done and justifications for why this is needed.
Time expectations	13	18	Some disabled victim-survivors needed more time to enable their access needs to be met and for them to reach similar outcomes to non-disabled victim-survivors who had successfully engaged with victim support services. This group included justifications for why extra time was needed and experiences of being given

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Name	Files	References	Description
			extra time (or not) and the impact of this extra time (or not).
Turning points	7	8	Some respondents described initial negative experiences when seeking to access victim support services, until they encountered a single person/ practitioner or a welcoming service that enabled them to engage successfully with victim support services.
Online and/or Offline	13	17	Respondents justified their preferences for online and/or offline support.
Effective referral and signposting to an appropriate service	22	56	Respondents described their routes into victim support services, including effective referral and signposting to an appropriate service.

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### **(III) BARRIERS and negative experiences**

This group of codes included respondent's negative experiences.

<b>Name</b>	<b>Files</b>	<b>References</b>	<b>Description</b>
Barriers at point of access	15	29	This included barriers encountered by disabled victim-survivors at initial point of contact with victim support services, which instantly "put them off".
Material barriers	28	85	This code focussed on socially created material barriers (Priestley 1998) to accessing and engaging effectively with victim support services, including physical accessibility issues and lack of communication support.
Attitudinal barriers	18	65	This code focussed on socially constructed, idealist barriers (Priestley 1998) encountered by disabled victim-survivors.
Wait times	9	14	Respondents described the time between being referred to a service and the service

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<b>Name</b>	<b>Files</b>	<b>References</b>	<b>Description</b>
			starting. These experiences were mostly negative, but respondents made some suggestions on how wait times could be bridged more successfully.

### **(IV) Police and CJS**

This group included both, positive and negative experiences.

<b>Name</b>	<b>Files</b>	<b>References</b>	<b>Description</b>
SARC	9	12	Respondents described their experiences at the SARC.
Police reporting	21	106	Respondents described their experiences of reporting to the police. Due to the focus of this report on victim support services, only little of this data was used.
CJS – getting	18	38	This included respondent accounts of going through the CJS, their experiences of going

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Name	Files	References	Description
justice or not			to court or their experiences of being denied or accessing justice.
Reasons for not Reporting	15	21	Respondents who did not report to the police explained why they had not reported. Some respondents who have had negative experiences reporting also stated why they would not report if they experienced another crime.

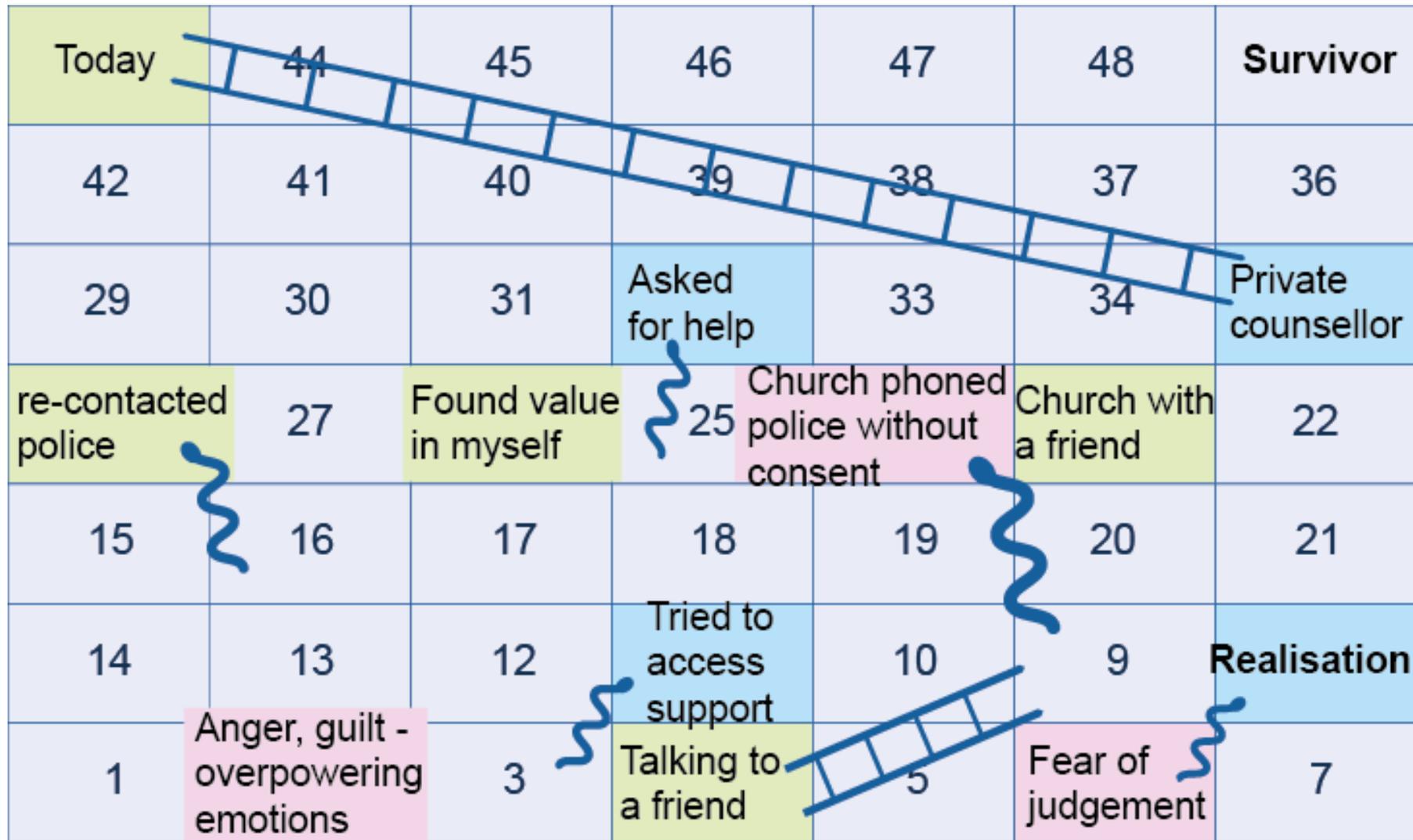
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## **Appendix F**

### **Case study Olivia and Sean: Paying for the turning point**

**Figure 8: Olivia's "Snakes and Ramps" board**

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### Further information

11 'They didn't want to believe me'

If you're disabled you just have to accept it

Helpline - 'you'll feel alright in the morning'

28 Physical barriers - height of desk, noisy

Environment felt clinical, not cared for

32 Wait in the rain for ramp

GP waiting list for counselling

'If you can't trust me, this won't work'

35 Felt accepted, belonged there

It was already accessible

Private counsellor - what access needs do you have?

Explored different options together, listened to

43 Working for a charity with victims of rape/ sexual assault

Shared experiences of barriers

Respect boundaries

Celebrating the journey I have been on

## **Realisation**

Although Olivia had come to the realisation that she had experienced sexual violence while talking to a friend about what happened to her, she felt lonely and found it difficult making sense of what happened. She directed a lot of shame and anger towards herself and admitted to feeling “stupid” for “letting it happen”.

## **Negative experiences**

Olivia first tried accessing support by calling a crisis helpline, but was shut down quickly: “All they seemed bothered about was whether or not I had the intention to commit suicide”. She felt she was treated differently and not believed because of her impairment. Sean also experienced barriers and explained that “trying to get people to understand what my needs are” is a big issue. This resulted in him not reaching out to support for “over 50 years.”

Olivia started attending church with her friend and built a trusting relationship with the minister. She

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disclosed her experiences to the minister and was initially well supported. However, they broke this trust by reporting her case to the police without her consent: “It just felt like my world in that moment fell apart... and it felt like I was losing control.” She withdrew from church entirely and “pretended that it [sexual violence] didn’t happen.”

Olivia eventually went to the police contact around a year later but explained that the building was ‘clinically cold’ and not “disability friendly”. The reception desk was only accessible at standing height and the reception area was noisy. Olivia left before recording any formal information about the incident. Sean described physical barriers that prevented him accessing support successfully. He needed to see people’s lips moving to communicate, but he was only provided with phone numbers.

Around 6 months after contacting the police, Olivia secured GP counselling. She immediately

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encountered a physical barrier when she had to wait outside in the rain for a ramp. She then struggled to open up to the allocated counsellor who told her that the process would not work if she could not trust her. Sean also attempted counselling accessed through his GP. The counselling service did not provide the captioning he required during video calls with him describing the service as not being “geared up to help people like me”. Both Olivia and Sean were let down by these counselling services.

### **Positive experiences**

Olivia paid for a private counsellor who advertised on her website as specialising in both disability and sexual violence. Olivia explained the very first encounter with the counsellor

“Her first question to me was: ‘What access do I need to put in to make sure you can access the services? What do you need from me?’ She had a ramp to get into the front door. She had a quiet

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area. We had the option of sitting inside or outside, and I said: ‘It would really help me if there was a blanket on hand, so I’ve got something soft and tactile to fiddle with as I talk.’”

Olivia described feeling “accepted” – it was a space for her to feel safe and be herself. She reflected upon how calm the process was: “There wasn’t frantic voices. There wasn’t harsh tones. Periods of silence were okay. It was just the space. It was a space to be and a space to be me. I didn’t have to apologise for it.” Everything was a discussion and decisions were made jointly. Olivia felt like there was an equal relationship between the counsellor and her. The counsellor helped Olivia to find meaning in herself and to take back control of her life. She felt empowered by the time taken and flexibility offered, which contrasted with her previous experience. This counsellor was the start of a turning point for Olivia. Olivia now celebrates the small things that she achieves and works with a

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charity who get referrals through for women. She reflected upon her involvement in this research as a moment to celebrate.

Sean self-funded a counselling service which was trained in D/deaf inclusive communication and equipped to provide the captioning that he required for the remote counselling sessions to be accessible.

Sean described his counsellor as “absolutely brilliant”.

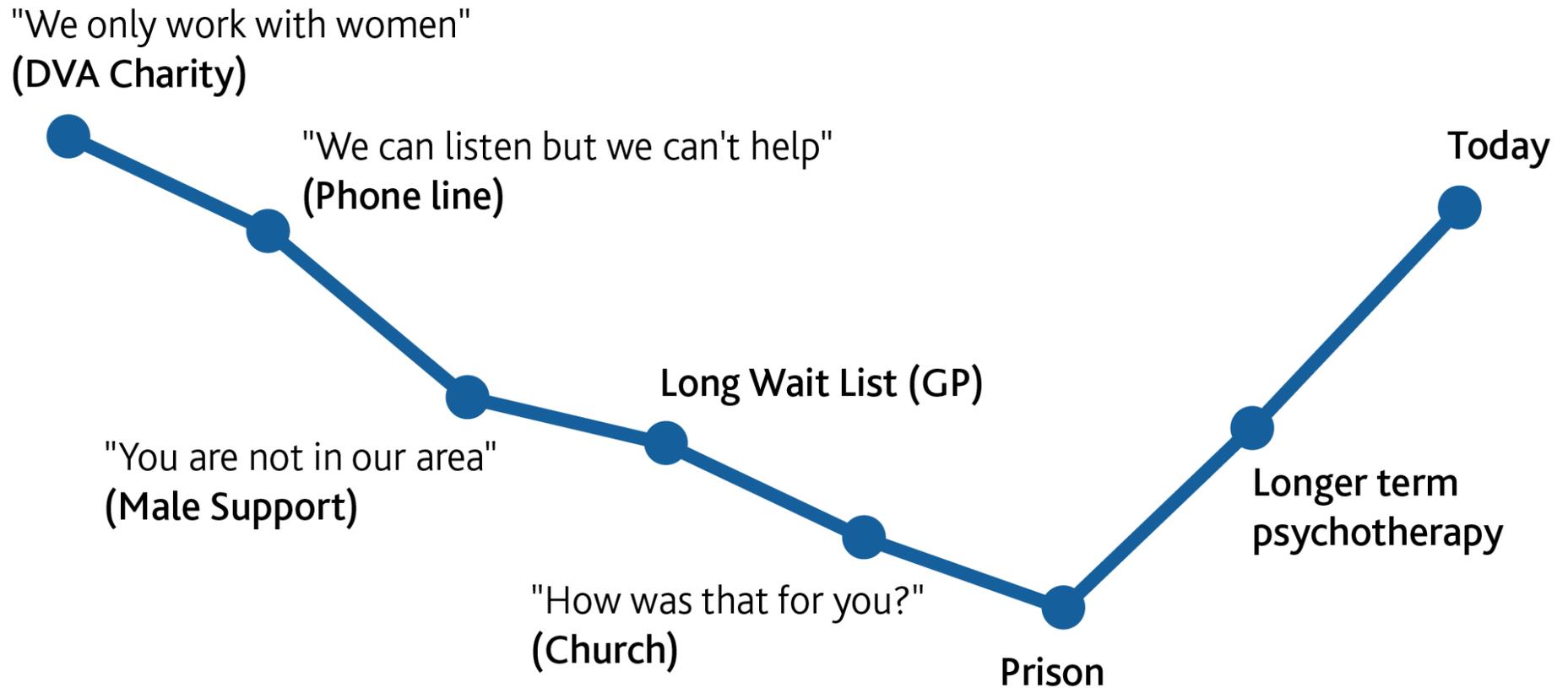
He stated that he did “not know where [he’d] have been” today without the counselling. Sean suggested that similar services to the one he was using needed to be made available for all and that D/deaf inclusive communication skills training was required within all counselling services, as not everyone has the ability to pay for private counselling.

## **Appendix G**

### **Case study Thomas: Bounced from service to service**

Thomas had a mental health condition, which was managed well. He worked successfully in a corporate job. His wife developed a sexual fetish. She raped and tortured him for several years. Thomas' mental health deteriorated. Once he fled the violent relationship Thomas embarked up an increasingly frustrating journey to find a service that would work with him, as illustrated in figure 9.

**Figure 9: Thomas's journey towards accessing support**



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Thomas tried to access several different services but was turned away by services who said they “only deal with women” or that Thomas was “not in their area”. He contacted a helpline, who advised: “We’re not the type of charity that can support you. We can listen to you, but we can’t support you.” When he was eventually signposted to a male victim support organisation, he was told that the membership starts at £190. As Thomas had to give up work, due to the deterioration of his mental health, this membership was not an option. He approached his GP but was told that there was a two-year wait. Thomas found himself in what Carly termed in section 4.2 “a signposting roundabout of nothing”. Just like Carly he was not accepted into services, as he was considered “too complex”, due to his mental health conditions. He found that those he tried to talk to about his experiences were ill equipped to have this conversation: “I went to the church and the church

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were very nice, but not trained. When you talk about anal bleeding, they say: ‘Yes, how was that for you?’”

Thomas deteriorated and committed a violent (non-sexual) offence for which he went to prison. It is important to note here that having experienced interpersonal violence is never an excuse for hurting others, but an explanation is that sometimes hurt people will move on to hurt others. What signifies Thomas’s case is that he knew he needed help and kept asking for help, but he was bounced back from services upon every approach, or he was given inappropriate support (church) or not enough support (telephone line). Thomas explained: “I hit the wall in a bad way, and then it took a lot of recovery.” After prison Thomas accessed a specialist, residential long-term treatment programme, which comprised both group and individual sessions.

“I went in with the approach it was something better than nothing. Because I’ve already been

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kicked around like a football with all the nonsense of not getting support. But it exceeded my expectations because they listened – they didn't judge, but more importantly they seemed to understand. [Treatment] started to fill the tank up with the various topics of self-confidence, assertiveness, reassurance, depression, what is anxiety, how to deal with it, how to measure, what if you have a bad day. [It] enabled me to become the man that I am today.”

Thomas asserted that he will never be able to work in his former profession again, due to his mental health, but he wanted to give back and help others, which is why he worked as a peer mentor for people who have come out of prison, and he was training to become a counsellor. He claimed: “My mental health has been made stronger by being stimulated into such a thing.” However, Thomas also said that to this day, he has

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been unable to progress to another relationship and that his healing journey was still continuing.

## Appendix H

### Case study Paula: Trapped during lockdown

Paula is a woman with physical impairments who does not use speech. She was interviewed face-to-face in the presence of a relative, who verbalised Paula's experiences. Paula communicated using body language to guide her relative in explaining what had happened and to assent or disagree with how they had phrased Paula's experiences.

During Covid-19 lockdown and beyond Paula experienced repeated sexual violence, as well as other forms of maltreatment and dangerous care practices by a female carer within a communal establishment. Paula tried to communicate what had happened to her, but it took a long time for her to be heard due to the restrictions of online communication. Paula's relative recalls their Zoom calls:

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“‘Are you okay?’ and we did ask, ‘Is everything okay with your care?’, but you weren’t in a private, you weren’t in a situation where you were private, and you couldn’t tell us, is that right? [cue from Paula] Yes.”

When Paula had physical contact with her family again, she tried to tell a relative:

“The first person you tried to tell [relative] didn’t you, but with Paula not being able to vocalise and she was trying to show [relative] that she was being, something was happening, [relative] didn’t really go to ask the right questions because [relative] didn’t think to ask that something like that would be happening.”

Family and carers became concerned a few months after Paula returned to her day-care setting, due to changes in her behaviour. Paula was eventually referred to a clinical psychologist who specialises in

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working with people with speech impairments and Paula was able to tell them what was happening.

“The day that Paula had that disclosure, you’d had abuse on that morning; and I think it was just the final straw; Paula was not going to have it anymore. No, no more. You wanted it to stop didn’t you [cue from Paula], yeah, and you didn’t feel safe did you? [cue from Paula] No.”

The case was immediately reported to the police. Paula was however not referred to a sexual violence support service. The police did not signpost her to the SARC and she did not have a forensic medical examination. After the initial reporting Paula’s family had to “keep pushing the police” for Paula to be able to give her statement. The police eventually advised that Paula needed to be referred to a specialist unit within the police, who involved a justice intermediary. Paula had to wait twelve weeks to make the initial statement and evidence was lost, as Paula found it

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harder to recall details about the violence than she would have done closer to the day she disclosed. Even though the police reportedly believed Paula, they eventually closed the case, due to a “lack of evidence”:

“We were told by the police that the abuser would have a flag on their DBS,<sup>19</sup> so we were shocked to find that, that she’s back working, not only with that organisation but back in that particular unit.”

At the time of the interview Paula was living in emergency respite, whilst the abuser was back at their place of work. Paula and her family felt “lonely” and powerless:

“Paula still wants her story to be told somehow. Not to the point where she wants to upset

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<sup>19</sup> DBS – Disclosure and Barring Service: A check of criminal record, which will show details of all spent and unspent convictions, cautions, reprimands and final warnings held on central police records.

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others... Whilst everybody was complaining that they couldn't get out for longer than half an hour during the lockdown or go to [supermarket], Paula was isolated and in a very different situation. It would be really useful for people to know that behind closed doors during the pandemic it gave a wave of opportunity to people who took advantage of that. I think you'd like to have your say, wouldn't you? [cue from Paula] Yeah."

## **Appendix I**

### **Peer support offered during a focus group**

One of the focus groups took place at an inclusive women's refuge. All the women who participated in the group had learning disabilities and/or autism and most also had significant mental health difficulties. The focus group was conducted by Leah and Andrea. The respondents have self-selected their pseudonyms (Lilly, Queenie, Peppa and Sharie).

At the start of the group the women shared what had happened to them. One example was presented in section 5.5. A sense of peer support was upheld throughout the focus group and came through in the ways the women related to each other. For instance, Lilly first suggested the term "one big family" when commenting on Queenie's account of living together with the other women. The women offered each other

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advice and described the importance of allowing negative emotions:

Lilly: He hurt me so much. [...] I was crying. [...]

Sharie: Just cry.

Queenie: It is, it's healthy.

Leah: Good cry, let it out.

Queenie: Just remember what this is because this is about our past. I know it's going to be hurtful and that but remember if it's – you want to cry let it all out because it's helpful.

Peppa: [Staff] says that to me.

Queenie: Yeah, [staff] says it always to me and Peppa. If anything like brings you back to your past just cry and go out for some fresh air.

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Leah: And it's so nice that you've got each other as well to help each other.

Queenie: One big family we are.

Peppa: We call each other sisters, don't we?

Queenie: All three of us call each other sisters. She's the oldest, out of them two she's the oldest. And I'm here, I'm the baby.