Ministry of Justice

BOLD
Delivering Better Outcomes by Linking Data, evidence and experiences

An adult victim-survivor's journey through a sexual violence support service in Essex

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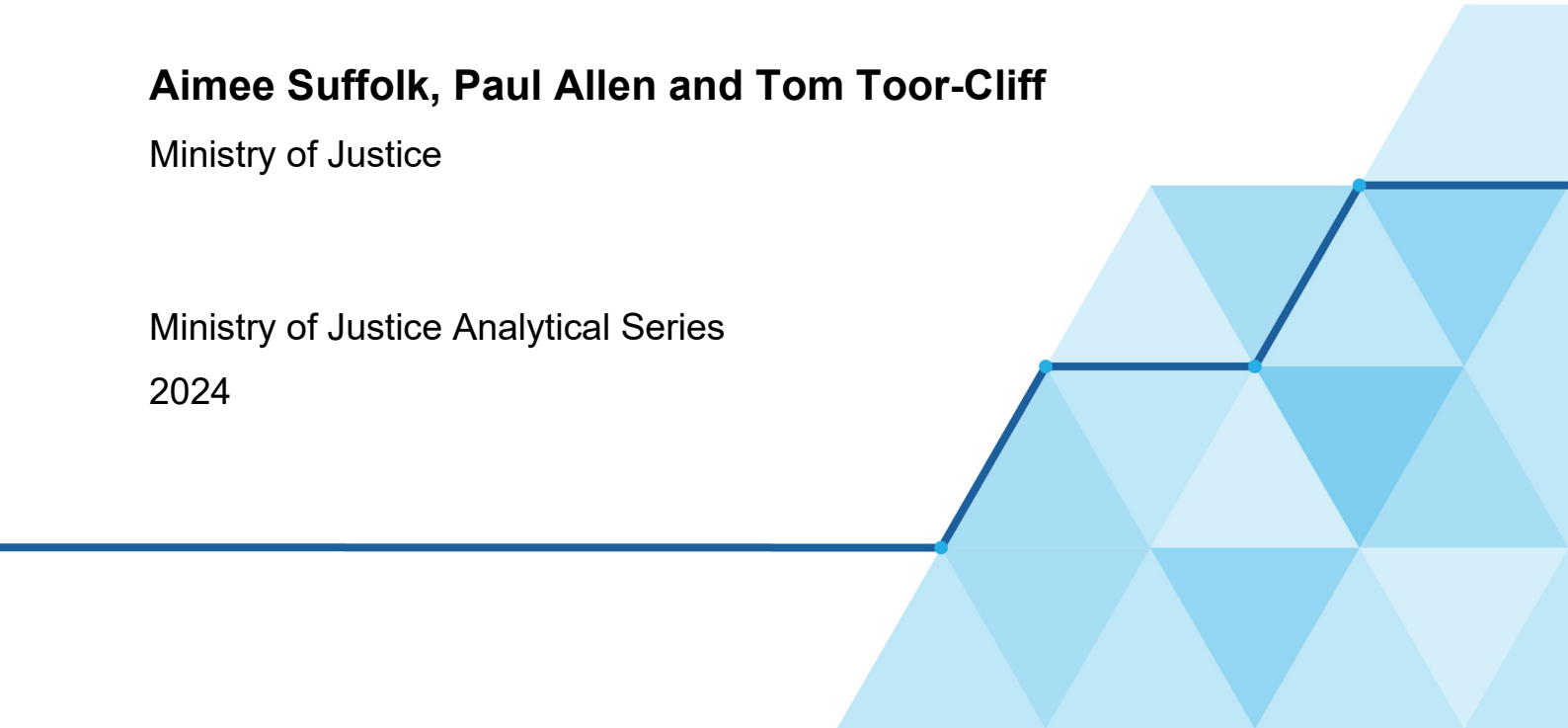

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1. Executive Summary

1.1 Research context

BOLD (Better Outcomes through Linked Data) is a 4-year cross-government programme led by the Ministry of Justice (MOJ). It was created to show how people with complex needs can be better supported by linking and improving the government data held on them in a safe and secure way. Consequently, policymakers and those working in UK public services will have better quality evidence by joining up the evidence and data used to run services. You can find more information on the BOLD programme at Ministry of Justice: Better Outcomes through Linked Data. The Victims Pathway Pilot of BOLD aims to achieve this for victims of crime.

Data collection across the many organisations that collect victim's data is relatively unstandardised,[1] varying in quality, completeness, and accuracy (The Centre for Justice Innovation, 2023). This includes different government departments, agencies, and third sector service providers. Decentralised and fragmented data means that the victim journey through the CJS (criminal justice system) and victim-related services is only partially understood. Victim support services were identified during BOLD's discovery phase as key organisations that hold detailed victim-level data.

There is a lack of understanding within government around what data is held by victim support services and how it could be linked safely to other government or third sector organisations to improve outcomes for victims. Furthermore, there is a lack of robust evidence within the wider literature that explores third sector support service data and the data held on victims who attend support services. This report contains exploratory descriptive research on third sector sexual violence support service data as the first step in a wider effort to better understand the victim's data landscape.[2]

1 Ministry of Justice. (2023). Victims Funding Strategy. Victims Funding Strategy - GOV.UK (www.gov.uk)

2 Available data sources relating to victims of crime, from a range of different sources across government departments, agencies, and third-party service providers. This also covers data maturity within the context of this report.

The primary aims of this research were:

- to discover what data a specific third sector service holds and to examine the completeness of the data,
- to understand if it is possible to use this data to assess the services that victim-survivors[3] need and identify typical support packages offered,
- to examine a victim-survivor's journey through a support service and,
- to understand if it is possible to use this data to understand victim-survivor disengagement from the support service.

Secondary aims were to understand how this data fits into the wider victim data landscape and understand the benefits of linking this data to other organisations. This research is the first step to realising the potential benefits, insights, and context that data collected in a third sector support service environment can provide to the wider data landscape.

The Victims Pathway Pilot has formed a partnership with SWERCC (South and West Essex Rape Crisis Centres), which includes two out of the three Rape Crisis Centres in the Synergy Essex[4] partnership (SERICC and Southend on Sea's Rape Crisis centres (SOSRC)). SWERCC provides information and specialised support services, such as advocacy and counselling, to anyone who has been sexually abused or raped, or who has been affected by sexual violence at any time of their lives. SWERCC shared a snapshot of their data which includes information for victims who were over eighteen, where a consent form had been signed from 2018 onwards.

The SWERCC dataset includes high quality, complete data that is primarily victim-level. This is often not routinely collected by the government and CJS organisations. Linking third sector support service data to data held by government departments and other organisations such as the police and the Crown Prosecution Service (CPS) could allow a more comprehensive understanding of victim attrition and victim needs to be developed.

Third sector support services could provide the victim lens data to the data landscape that is required to build an evidence base around what works for improving victim engagement

[3] Victim-survivor is defined as an individual who has used or is using the SWERCC service.

[4] Synergy Essex I Rape and Sexual Abuse Specialist Services

with the CJS process and support services. As a result, policymakers could have better quality evidence to support data-driven policy decisions.

1.2 Key findings

- For victim-survivors who completed a before and after questionnaire, it is indicated that engagement with SWERCC has a positive impact on a victim-survivor's ability to cope and build resilience and is therefore working as intended for those who engage with the service.[5]
- As expected from the wider literature, the most common victim-survivor typology for those who are over 18 years of age is females between the age of 18 – 44 with a primary incident of rape (42%).
- Police forces are the most common referral stream into the service (33%), almost all of which are from Essex Police. Most referrals are received from non-police sources.[6]
- The most common risks, issues and impacts across all primary incident types suggest that victim-survivors most commonly attend the service with needs relating to mental health and psychological wellbeing.[7]
- Over half of victim-survivors (57%) waited for more than two years before reaching out to seek support and contacting specialist services.

[5] Of victim-survivors who completed a before and after questionnaire, 85% had an improved score. Completing an after-service questionnaire is most common amongst cases that end in a planned closure.

[6] Self-referrals are the second most common referral source (27%). This is followed by healthcare agency (22%), support service (11%), local authority (4%), and other (2%).

[7] The most common risk was at risk of mental health (17%). Post-trauma symptoms were the most common issue (49%) and impact (58%).

- Victim-survivors who waited more than two years to seek support had a higher prevalence of poor mental health (31%), compared with those who waited less than a week (24%), and those who waited between a week and a month (21%). However, it is unclear if poor mental health was pre-existing (before the incident), or as a result of the incident.
- As expected from the wider literature, the most common type of perpetrator is someone known to the victim-survivor (81%).
- The most common service accessed was therapy (38%). This was followed by the use of the wraparound service (both therapy and advocacy) (20%).
- The largest level of attrition from the service happens between the initial referral and the victim-survivor completing an assessment of needs (34%).
- Nearly 50% of all cases disengage before receiving any type of service.
- Disengagement from the service is highest amongst police referrals, with only 26% of cases ending in a planned way. Those who self-refer are least likely to disengage, with 43% ending in a planned way.
- Disengagement from the service is most common amongst 18 – 44-year-olds. Victim-survivors under the age of 44 had a planned closure rate of 32%, compared with 40% for victim-survivors over the age of 44.

2. Introduction

The Crime Survey for England and Wales (CSEW) estimates that in the year ending March 2022, 1.1 million adults aged 16 years and over experienced sexual assault.[8] Rape and sexual violence are devastating crimes that can have life-long impacts on victims. The direct trauma that they experience can impact their psychological, emotional, physical, social, and financial wellbeing. The trauma can also impact those around them, extending to their family, children, and friends through what is known as secondary trauma (Boyd, 2011). When an individual takes the step to report a crime or seek support, it often results in them reliving their personal trauma. A challenging and emotional experience heightened by the individual, social, cultural, and structural barriers to accessing support that many face (Silk, 2023). As a result, it is vital that the CJS and third sector support services can support victims to cope, build resilience and seek justice.

Many people do not report the crime that happened to them or seek formal support. The CSEW for the year ending December 2023 estimates that fewer than one in six victims of sexual violence report to the police.[9] For those who do report, many disengage from the CJS process. Between July to September 2023, over half of all adult rape cases were closed because the victim did not support police action (61%).[10] Victims also experience multiple barriers which hinder engagement with the CJS and support services, including fear of not being believed, not believing the crime that happened to them was serious enough, or feelings of shame (Silk, 2023). Whilst this is not the case for all victims of crime, there are still far too many who feel that the system fails them and countless disengage, resulting in high attrition rates. However, there is little evidence to suggest what works for improving victim engagement.

Improving outcomes for victims of crime is a government priority. As part of the Victims and Prisoners Act,[11] the ISVA (Independent Sexual Violence Advisor) and IDVA

8 Sexual offences in England and Wales overview (ons.gov.uk)
9 Crime in England and Wales: Year Ending December 2023 (ons.gov.uk)
10 Criminal justice system (CJS) delivery data dashboard. Home - CJS Dashboard (justice.gov.uk)
11 Victims and Prisoners Act 2024 (legislation.gov.uk)

(Independent Domestic Violence Advisors) guidance is being developed.[12] The Victims' Code[13] has been updated and the Victims Funding Strategy[14] has set the vision for sustainable funding for the support sector. Furthermore, the End-to-End Rape Review[15] has set an action plan for improving the CJS response to adult rape cases, and the Rape Review progress reports have been published.[16,17] However, whilst some improvements to the system have been made, there are still many victims who do not report, and high attrition rates remain. Feedback from experience surveys suggest that victims are sometimes not informed about their Victims' Code entitlements and that there are still system-wide issues that negatively impact victims (Victims Commissioner, 2020; Victims Commissioner, 2021). The CSEW for the year ending March 2020 estimates that 23% of people who had been victims of crime in the previous twelve months were aware of the Victims Code.[18] Data suggests that efforts to improve outcomes for victims of crime are hindered by low quality victims' data that is held across many different organisations (The Centre for Justice Innovation, 2023; Stanko, 2023).

The BOLD programme has been designed to improve the design and delivery of services for people with complex needs, by better joining up the evidence and data used to run these services. Consequently, policymakers and those working in UK public services will have better quality evidence on what works in four main areas. The four main BOLD demonstrator pilots focus on: reducing homelessness (led by the Department for Levelling Up, Housing and Communities), supporting victims of crime (led by MOJ), reducing reoffending (led by MOJ), and substance misuse (led in England by Office for Health Improvement and Disparities and in Wales by Public Health Wales). It is a 4-year

[12] Clause 15; Guidance about independent advisors (ISVAs and IDVAs) - GOV.UK (www.gov.uk)

[13] Code of Practice for Victims of Crime in England and Wales (Victims' Code). The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK (www.gov.uk)

[14] Ministry of Justice. (2023). Victims Funding Strategy. Victims Funding Strategy - GOV.UK (www.gov.uk)

[15] End-to-End Rape Review Report on Findings and Actions. End-to-End Rape Review Report on Findings and Actions - GOV.UK (www.gov.uk)

[16] Rape Review Progress Report: Two years on. Rape Review Progress Report: Two years on - GOV.UK (www.gov.uk)

[17] Rape Review Progress Report: Winter 2024. Rape Review Progress Report: Winter 2024 - GOV.UK (www.gov.uk)

[18] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/adhocs/13635experienceofthecriminaljusticesystemforvictimsofcrimeenglandandwalesyearendingmarch2009toyearendingmarch2020

cross-government programme led by MOJ that was created to show how people with complex needs can be better supported by linking and improving the government data held on them in a safe and secure way.[19] The Victims Pathway Pilot is a 4-year proof of concept pilot that aims to explore this from a victims' perspective. The aim is to unlock insights into supporting victims of crime, such as understanding their end-to-end journeys, experiences, effectiveness of victim services and factors behind victim attrition rates at different stages of the CJS.

Discovery work was carried out in the scoping phase of the programme to explore the current victims' data landscape. It was found that victims of crime encounter many organisations, with over 1,000 organisations who each collect some data on the victim experience. Approximately 700 of these organisations are third sector victim support services. Some victims may have to give the same information to access support services which can be an emotional and traumatic process (The Centre for Justice Innovation, 2023). The data collected at each stage of the journey is unstandardised and disconnected, with high variability in quality, completeness, and accuracy both between and within sectors. This results in challenges in understanding deeper victim needs to allow effective and tailored support at each step of the journey. Furthermore, if victims' data lacks quality and accuracy it limits the potential benefits of data linking. As a result, the first step is to improve victims' data maturity and quality so that quality data can be linked to provide accurate insight.

During the discovery phase, victim support services were identified as a key part of the victim journey. There is a lack of understanding within government around what data is held by support services and how the data could be linked across organisations to improve outcomes for victims. It was expected that their datasets would include information such as demographics of those who enter the service, and what support was accessed. As the aim of support services is to deliver appropriate support that meets victim needs, it was also expected that their datasets may include key information that could unlock insight to support a deeper understanding of victim needs that CJS data often lacks. For example, whilst police data shows how many individuals withdraw from the process resulting in no

[19] Ministry of Justice: Better Outcomes through Linked Data (BOLD)

further police action, support service data could potentially add context to understand why those individuals disengaged or provide insight into which services improved engagement.

The Victims Pathway Pilot formed a partnership with SWERCC, which includes two out of the three Rape Crisis Centres in the Synergy Essex partnership (SERICC and SOSRC) who shared their data for the purposes of this research.[20] The services provide specialist sexual violence and sexual abuse services to anyone who has been sexually abused or raped, or who has been affected by sexual violence at any time of their lives.[21] This is regardless of whether the incident has been reported to the police.

As a proof-of-concept feasibility project, the primary aims of this research were:

- to discover what data a specific third sector service holds and to examine the completeness of the data,
- to understand if it is possible to use this data to assess the services that victim-survivors need and identify typical support packages offered,
- to examine a victim-survivor's journey through a support service and,
- to understand if it is possible to use this data to understand victim-survivor disengagement from the support service.

Secondary aims were to understand how this data fits into the wider victim data landscape and understand the benefits of linking this data to other organisations. This research is the first step to realising the potential benefits, insights, and context that data collected in a third sector support service environment can provide to the wider data landscape.

The findings from this report are based on a snapshot of data held by a specific support service in one geographical area and includes only victim-survivors of sexual offences. As a result, the findings cannot be generalised and should be considered as exploratory research that is the first step in a wider effort to improve outcomes for victims by improving and understanding the data that is held on them.

[20] This included information for victims who were over eighteen, where a consent form had been signed from 2018 onwards.

[21] Synergy Essex | Rape and Sexual Abuse Specialist Services

3. Methodology

3.1 Key Definitions

Analytical Platform – A secure data analysis platform made up of tools, packages and datasets for creating applications that utilise data within the Ministry of Justice. (Link: https://user-guidance.analytical-platform.service.justice.gov.uk/)

Case – A period of interaction between a victim-survivor and SWERCC

CSA – Child sexual abuse.

DPIA – Data Protection Impact Assessment. This is a risk assessment designed to identify and minimise the privacy risks that come with using, storing, and sharing data. It outlines lawful reasons for sharing data.

DPMS – Visia Data Performance Management System. A specialised data management system used by both centres in SWERCC.

First Contact Navigator Model – A team specially trained to work with victims of sexual violence and child sexual abuse to provide guidance and advice relating to the services available in the local area, helping to access the right support, at the right time.

Victim-survivor – This is used when referring to those using the SWERCC service.

Victim – This is used when referring to victims of sexual violence in general.

Primary victim-survivor – A person who has directly experienced sexual abuse or sexual violence.

Secondary victim-survivor – A family member, partner, friend or anyone affected because someone they know or care about has experienced sexual violence.

SWERCC – South and West Essex Rape Crisis Centres. SWERCC consists of two of the three centres in the Synergy Essex partnership: SERICC Rape and Sexual Abuse Specialist Service and Southend-on-Sea Rape Crisis (SOSRC).

3.2 Data Share

The shared data represented a snapshot of the SWERCC database as it existed on the date of the share, 5th May 2023. It contained information from two out of three of the Synergy Essex centres for victims who were over eighteen, where a consent form had been signed from 2018 onwards.

All cases for consenting victims were shared, regardless of when the case started. This means a small number of cases contain information about support and incidences provided when the victim was under eighteen because the victim provided consent to share this data when they were over eighteen years old.

For details of the data sharing process, see Annex 1.

The data that was in scope to be shared was solely the data that had been completed using drop-down options in a standard format, with no free text fields provided. This was due to the potential for personal identifiable information, (PII) to exist within the free text fields. The level of resource and time needed to deidentify the data was deemed to be too much for this project, therefore free text fields were out of scope.

Unique keys were present in each data table to allow the ability to link records across tables.

Within the data was information about 6,457 cases where the victim-survivor had been referred to the SWERCC service between June 2001 and May 2023. In 5,851 of these cases that period of interaction had ended by the time of the data share. This is known as a closed case, regardless of outcome.

3.3 Analysis

As the purpose of this project was to look at a victim's journey through the support service, analysis was split into the four stages of the victim's journey through SWERCC service

that had been identified; referral, needs assessment, types of services offered/received and closure of these services. See section 5 for more detail on these stages.

The focus of the analysis was to identify characteristics of those who were referred to SWERCC, how they interacted with the service, and if the service ended in a planned way.

A service ends in a planned way and is closed when a victim-survivor feels that they have received all that they need from the service to enable them to cope and build resilience and agree with their workers that they feel they no longer need the support.

If the service did not end in a planned way, known in this report as an unexpected closure, analysis was conducted to understand at what point in the victim-survivor's journey disengagement happens and explore potential patterns in those that dropped out prematurely.

There were small numbers of victim-survivors with primary incidents other than rape and CSA. For this reason, analysis primarily focussed on the two larger groups.

To simplify the data, some variables were grouped, where deemed appropriate. This helped to reduce the number of categories for analysis and improve data visualisation.

Analysis on whether protected characteristics affect aspects of the journey such as longer times on waiting lists, longer time spent in service or high unexpected closure rate was carried out. However, no significance was found. This could be tested on a larger scale to analyse whether there are significant differences.

3.4 Limitations

Only data that had a legal basis to be shared with BOLD was available to a limited number of analysts, as outlined in the DPIA. This means that the dataset represents a sample of approximately 64% of the full SWERCC adult caseload.

The dataset contains information about victims-survivors of rape and serious sexual assault in the south and west Essex area who had been referred to specialist support services. Therefore, these findings must be viewed within this context and cannot be generalised for all victims and their experience.

One referral method into SWERCC is via the Direct Police Pathway Model. A feature of this model is that all rapes reported to Essex Police are referred to SWERCC within 24 hours of report, if the victim-survivor gives consent. This means SWERCC can offer initial support and early interventions when police are not immediately able to allocate an officer in the case. One third of the SWERCC caseload that was shared were cases referred by the police (33%). This may not be the case in services that do not use the direct police pathway model and therefore do not have the same direct throughline from the police. This means that victim-survivor's experience in other services in other areas may be different.

SWERCC deliberately keep referral form mandatory fields to a minimum to reduce the potential of this being a barrier to service. Therefore, if a victim-survivor disengaged from the service before completing an initial assessment, there was very little information recorded about them. This means it was difficult to identify any characteristics that may be common to this group compared with those who engage in the service for longer. Once the assessment has been completed, this issue is much less apparent.

During the case, SWERCC continues to build the picture of the victim-survivor as trust increases and more information is obtained. The longer a victim-survivor engages with SWERCC, the more information SWERCC gather about them.

Victim-survivors were able to provide their disability information in numerous fields throughout the assessment phase, (see section 5.2 for further details). However, it is important to note that most of the data, including disabilities, ethnicity, gender, for example, is self-reported by the victim-survivor. Therefore, SWERCC are reliant on what information the victim-survivor wants to provide.

It is also not always possible, using the information in the drop-down fields, to understand if risks and issues faced by the victim-survivor existed prior to the incidents that happened to them, were caused by the incidents, or if these incidents heightened these risks and issues faced by the victim-survivor. This information might be recorded in the free text fields, but this was out of the scope of this data share.

SWERCC use the information collected at the assessment stage to assess what services best meet a victim-survivor's needs. There is no data available on the decision-making

process involved. Therefore, it has not been possible to conduct analysis of factors that may influence the service provided.

3.5 Data Quality

The data in scope of the share was the information that had been collected from victim-survivors and recorded in DPMS (Data Performance Management System) via drop-down options. This means that the variables were in a standard format, as SWERCC pick answers from a validated list of options. This leads to the data being in a standard format, and therefore easier to analyse than if it were not in a standard format.

Due to this, the main data quality issue comes from fields containing NA (Not Available) values or marked with a variant of Unknown, where the victim-survivor did not answer the question as they did not respond to SWERCC contact or did not want to provide the information.

Further details of the variables with missing values can be found in section 5.

Findings in this report are purely based on the data that was available and may not always be reflective of victim-survivors' lived experience.

4. Victim's Data Landscape

4.1 National

The evidence base on offender-related services is well supported by data within the CJS. However, victim-related services are only partially understood due to decentralised and fragmented data. Fragmented data is "a problem that happens when many organisations are required to publish the same data, but not to a common standard or in a common location" (Parsons & Powell-Smith, 2023). Victims of crime encounter many organisations which routinely collect information about them. Their data is held by a wide variety of different government departments, agencies, and third sector service providers.

This section of the report focuses on what victims' data is currently held and the quality of the wider victim's data landscape. There are currently multiple MOJ-led data improvement programmes exploring victims' data, including BOLD and Data First.[22] In 2021, discovery work was commissioned by BOLD to better understand the victim's data landscape. It was found that over 1,000 organisations in England and Wales support victims of crime and even within a given sector[23] there are variations in what data is collected. Data collection is relatively unstandardised, varying in quality, completeness, and accuracy. In addition, there are inconsistencies in the way organisations define and count key variables (The Centre for Justice Innovation, 2023). The scattering of information, data gaps, and lack of data sharing across the CJS and support services has resulted in barriers to achieving a holistic and data-driven understanding of the 'victim's' pathway', which is critical to developing effective policies and interventions. The Centre for Public Data (2023) define data gaps as "areas where a lack of official data means that questions of significant public interest cannot be answered".

Research carried out by the Centre of Expertise on Child Sexual Abuse (CSA) found that many support services were unable to provide information on the protected

[22] Ministry of Justice: Data First - GOV.UK (www.gov.uk)

[23] For example, the victim's sector, health sector, and CJS.

characteristics[24] of both adult and child victims that they had supported, with some services providing estimates in place of exact figures. The report recommends that support services receive funding to improve their data collection systems and analysis (Parkinson & Steele, 2024). Information on protected characteristics is also not routinely collected by statutory organisations, regularly missing from databases such as the Victim Contact Scheme (The Centre for Justice Innovation, 2023). This makes monitoring and researching disproportionality challenging.

The Operation Soteria Bluestone Year One Report found comparable issues. The operation was launched by the Home Office in 2021 in response to the End-to-End Rape Review that set out to increase the number of adult rape cases that reach the court stage. All four police forces included in the research had insufficient data systems and analytic capability to support strategic analysis to improve outcomes for victims of sexual crimes. Data fields reported as missing or incorrect include "victim ethnicity, the victim-suspect relationship and incorrectly applied outcome codes, in a significant proportion of cases" (Stanko, 2023). The Centre for Justice Innovation (2023) highlights that incorrectly entered data by the police extends to other government departments such as the CPS, who collate data from police systems. Furthermore, a lack of quality data makes monitoring performance problematic, such as compliance to the Victims' Code.

The Centre for Justice Innovation (2023) carried out a rapid literature review and interviews with key stakeholders in the victims' sector, including representatives from victims' organisations and data specialists within the CJS. The report explores the current data collection systems within the CJS and highlights limitations, gaps and problems that impact victims of crime. A limitation noted is that current crime recording methods only provide a partial view of the number of victims within society, as the CSEW excludes certain groups of the population, and victims who do not report a crime will not appear in police data. This results in many 'hidden victims' who slip through the net. For crimes that

[24] Nine characteristics are identified as protected characteristics including: age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex, and sexual orientation. Equality Act 2010 (legislation.gov.uk).

are recorded, a large proportion of the data held by government and CJS organisations solely focuses on the case and offender.

Another issue highlighted was a lack of data sharing (The Centre for Justice Innovation, 2023). Data relating to each part of the victim's journey through the CJS and support services is recorded on different databases and is owned by different organisations. As a result, despite attempting to improve outcomes for victims of crime, "not all of the data that can best support those actions is available to governments, or the right agency of government" (Capgemini Research Institute, 2023). Many victims will only appear in police data, some will also appear in CPS and courts data, and others will only appear in third sector support service data. Disconnected data and a lack of data sharing hinders the ability to develop a holistic understanding of a victim-survivor's journey and how each component interacts and impacts one another. This makes it challenging to identify weaknesses within the system as many issues are complex and involve multiple organisations.

Confidentiality concerns due to the sensitive nature of victims' data acts as a barrier to routine data sharing (The Centre for Justice Innovation, 2023). A lack of available unique identifiers to link victims in different datasets also makes it a challenge (The Centre for Justice Innovation, 2023). However, the value of unique identifiers, effectiveness of linked datasets and the quality of analysis produced is reliant on accurate complete data. It is also reliant on having an infrastructure in place to support data sharing. As a result, improved data maturity is the suggested prerequisite to having a unique victim identifier.

Whilst the sensitivity of victims' data and the importance of robust governance and ethical considerations when data sharing should not be overlooked, the benefits of collecting quality data that can be joined up to create integrated datasets must be realised. With high quality integrated datasets, policymakers are best placed to make data-driven and evidence-based decisions. Research commissioned by BOLD was carried out by Thinks Insight & Strategy,[25] formerly known as BritainThinks (2021) to explore the public's perceptions on the use and collection of their data. Whilst significant concerns relating to privacy and security were raised, the potential to realise societal benefits, alongside a

[25] Home - Thinks Insight & Strategy

specific and clear understanding on the use of data and what it contributes reduced the level of concern.

Data experts believe that poorly managed data is often a key driver of attrition (The Centre for Justice Innovation, 2023). A lack of reliable victim data makes it challenging to identify groups who experience barriers to access, withdraw from the process, and are not receiving support. We still lack a robust view of what the victim journey looks like through the CJS and victim support services. As a result, it is hard to identify and address victims' needs, best practice, what is working and what is not, or even understand the full volume of victims supported and what support they receive.

Where possible throughout the report, wider literature has been discussed which relates to the findings presented. However, there is a lack of robust research that explores victims who engage with support services based on data from third sector victim support services. Most of the research available, although still limited, focuses solely on those who do not reach out to seek support and the barriers that they experience, and those who disengage from the criminal justice process. This research aims to first understand what data is held by support services as a precursor to encourage further research that explores this concept.

4.2 SWERCC

During the discovery phase of BOLD, SWERCC was identified as a third sector sexual violence support service provider with expertise in the collection of victims' data. This is demonstrated by their involvement in creating DPMS and on-going commitment to support services that use the system.[26]

In 2008, the service identified the need for a specialised data management system and worked with an external organisation to create the DPMS. It is designed with a focus on sexual violence support case management, reporting and monitoring, performance management, understanding victim-survivors' needs, and contains a large amount of

[26] Since accessing this dataset SWERCC have an updated version of the DPMS which now includes more data fields. New data fields have not been included in this analysis as the data share was completed before the system was updated.

victim data. This includes victim-survivor demographics, protected characteristics, case information, support received, and questionnaires relating to their ability to cope and recover before and after they have attended services.

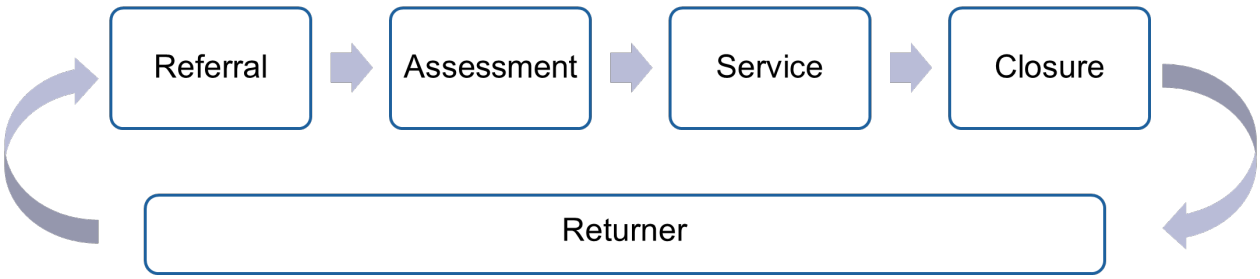
The system is now used by 27 Rape Crisis England and Wales (RCEW) member centres and 13 sexual violence support services that are not RCEW members. Each service has an individual database and data is not shared amongst them. RCEW also provide funding which allows the Data & Insight Lead at SWERCC to dedicate 22 hours per month to provide user support to other organisations who use the system. The system has evolved over time to ensure that service providers can record detailed information at each stage of a victim's journey through the service. The SWERCC workforce also includes 12.4 Full-Time Equivalent (FTE) Independent Sexual Violence Advocates (ISVA) and 17.33 FTE Counsellors. It is important to note that the findings in this report (e.g. waiting times, referral time, size and time on waiting lists etc) will be impacted by the size of the workforce in place and this is subject to change. For example, increases in referral volumes or number of victims-survivors who remain engaged in the service would need additional staff to deal with the increased demand. Without additional staff / funding for staff, such changes are likely to result in an increase in waiting lists for access to services or potentially decreased engagement from victims who are unable to wait. Therefore, the dataset provides insight into victim-survivors who engage with ISVAs and victim-survivors who receive wraparound support including both advocacy and therapy at this level of staff workforce.

The dataset is a management database and includes free-text fields. No free-text fields were shared as part of this data share due to the potential to break confidentiality. This adds to the challenge in carrying out statistical analysis in some areas due to the way in which some of the data is recorded. As a result, insight into certain areas of the journey is limited and has been noted throughout the report. Furthermore, it should be considered that data collection and quality will vary across organisations and not all third sector support services will hold the same data as SWERCC. Data quality will also vary amongst support services that use DPMS. Nevertheless, the dataset provides unique insight into the victim-survivor journey in South and West Essex and the typical package of support that they receive from the service.

5. The Victim-Survivor Journey

Each victim-survivor's journey through the support service is unique. It can vary depending on their needs, circumstances, and which specialist services they wish to access. Amongst the variations, there are four broad key stages that have been identified as common milestones in the support service journey. Many victim-survivors will complete their service programme of support from referral to closure, others may disengage and drop out of the service. This report explores each stage as shown in the diagram below. It highlights key findings that identify the typology of victim-survivors who access the service and provides insight into each stage of their journey.

Figure 5.1: The Victim-Survivor Journey



5.1 Referral

To access support, a victim-survivor must first be referred or self-refer to the service. The referral form is short and only minimal information is required at this point. This is to avoid victim-survivors and organisations being put off by excessive form filling and needing to share personal data before trust with the organisation is established. The initial referral stage shows who is being referred, how they are referred, and what crime(s) they have experienced. The demographic data which contains information on protected characteristics also provides insight into marginalised groups who are referred to the service.

An individual of any age or gender who is experiencing, or who has experienced, any form of sexual abuse or sexual violence at any time in their life can be referred. This includes

both primary victim-survivors (a person who has directly experienced sexual abuse or sexual violence) and secondary victim-survivors (a family member, partner, friend or anyone affected because someone they know or care about has experienced sexual violence).

The dataset includes 6,457 cases and 5,288 unique individuals. A case is opened for an individual and begins once a referral is received. A unique individual can have multiple cases if they return to the service after their previous case is closed (for more information see returners in the closures section of this report). There are 4,885 new cases and 1,572 returning cases. As previously mentioned, this is a snapshot of data including a proportion of service users over 18 who gave consent to be involved in research. Of all cases, 91% are primary victim-survivors, 8% are secondary victim-survivors, and 1% are not specified. Whilst findings show that referrals to the service are predominantly primary victim-survivors, the importance of embedded support for those indirectly affected is highlighted by the secondary-victim 8% referral rate. The findings below include all victim-survivors, including primary, secondary and those who did not specify.

Victim-survivors who are referred to the service and protected characteristics[27]

The most common victim-survivor typology, for those who are 18 or over when their case is started, is female between the age of 18 – 44 with a primary incident of rape.

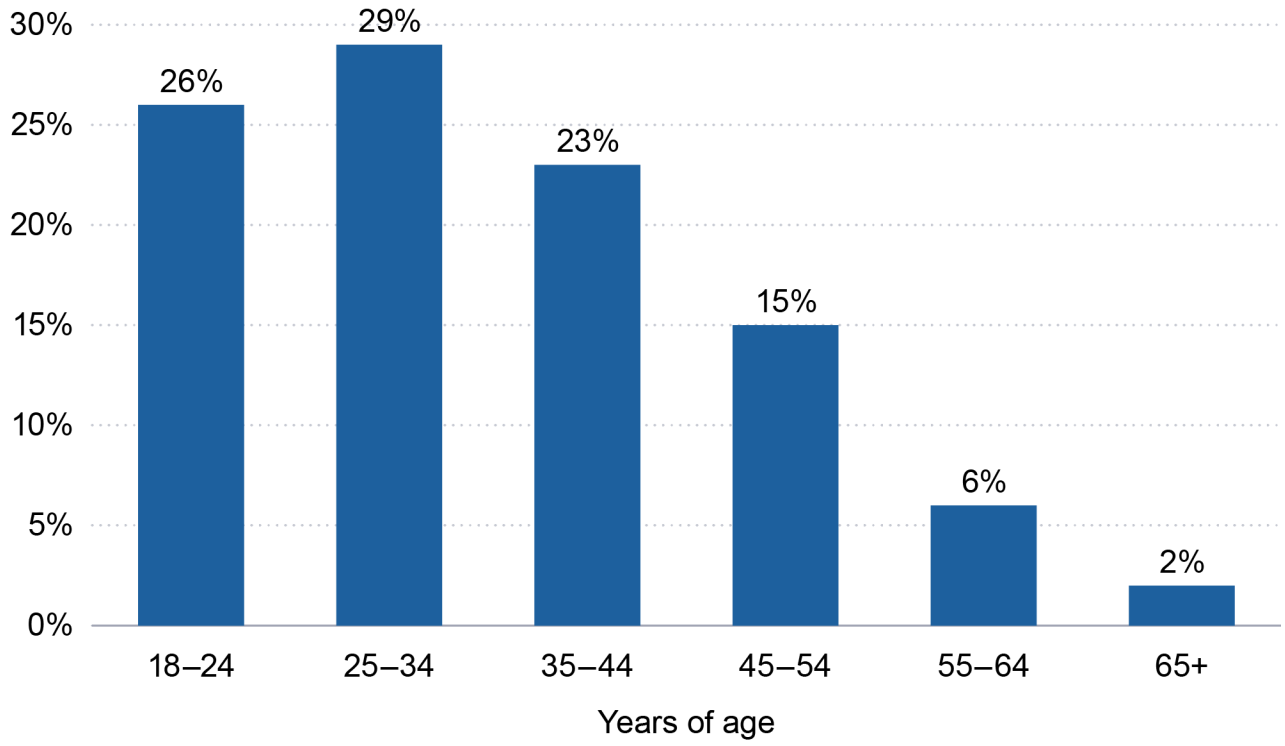
Most victim-survivors who are referred are female, making up 90.6% of all cases, 0.1% of which are trans females. Whilst males do access the service, there are far fewer cases with only 9% who are male, 0.2% of which are trans males. There are a further 0.2% of cases relating to non-binary individuals, and 0.1% of cases relating to trans individuals who do not specify their gender. Analysis could not be completed on these smaller groups due to sample size.

The most common age group is 25 – 34-year-olds, making up almost one third of all cases (29%). This is closely followed by 18 – 24-year-olds who account for 26% of cases. There is a decline in the total number of cases in older age groups, with only 23% of all cases

[27] These figures are based on all cases and includes both new and returning cases. Those less than 1% have not been included due to the small number of individuals.

linked to those over 45. Whilst the service does provide support to under 18s, they have been excluded from the dataset as discussed in the methodology section of the report.

Figure 5.2: Age breakdown of all cases in the dataset



Base = 6,385

Figure 5.2 covers all cases in the dataset, with start dates between June 2001 and May 2023, where age has been supplied and the victim-survivor was over eighteen.

Victim-survivors of a White British ethnic background are most prominent within the data making up 76% of all cases.[28] This aligns with the 2021 Census data that found in Essex a large proportion the general population also reported their ethnicity as White British (80%).

Of all cases, almost half said they had no religion (49%). The most common religion was Christian (14%). This was followed by Catholic (4%), Muslim (2%), Spiritualist (1%), and Atheist (1%).

[28] This is followed by any other White background (3%), Black African (2%), Black British (1%), any other Ethnic group (1%), any other Mixed background (1%), Black Caribbean (1%), White Irish (1%), Asian British (1%), White and Black Caribbean (1%).

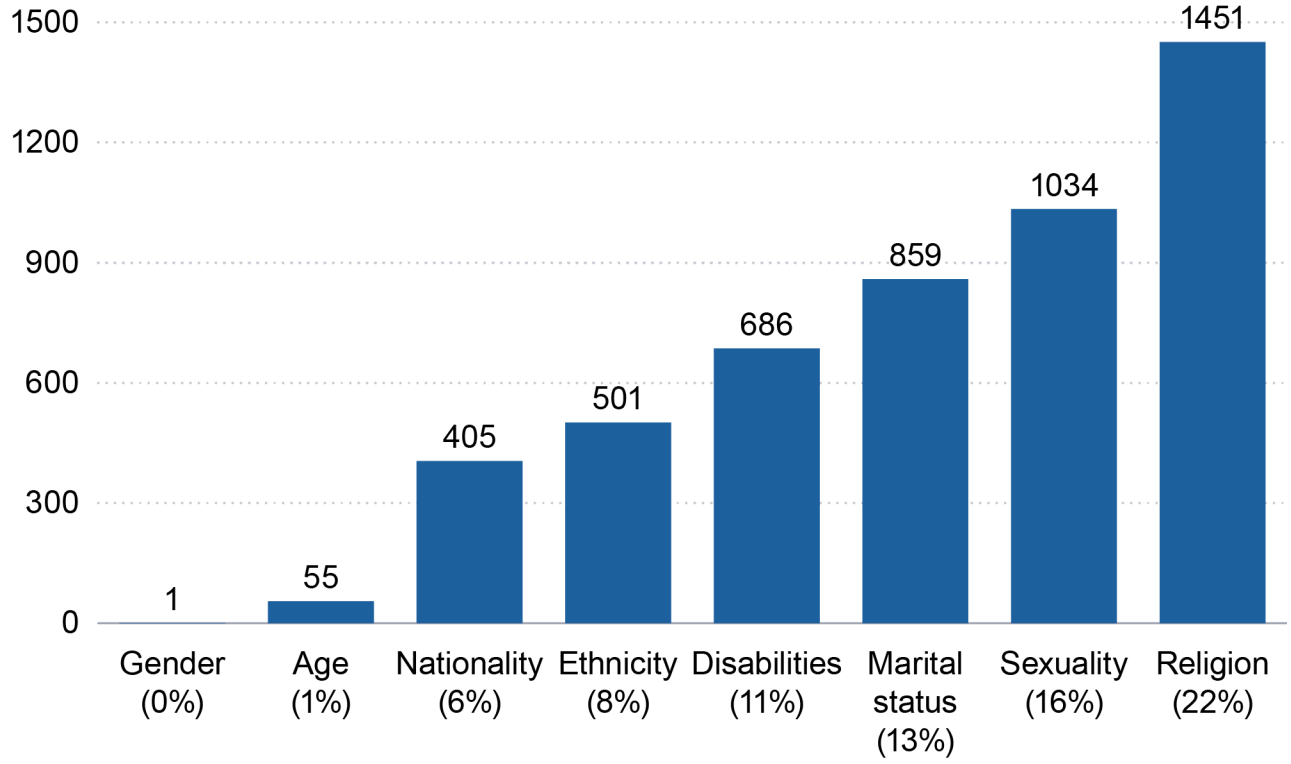
Heterosexual individuals are most common within the data, making up 74% of all cases. This was followed by bisexual (5%), lesbian (2%), and gay (1%).

In 43% of cases, victim-survivors reported being single. This was followed by those in a relationship (16%), married (12%), separated (7%), cohabiting (5%), or divorced (2%).

Almost half (44%) of cases had one or more disabilities recorded. The data does not indicate if the individual had a disability at the time of the incident. Mental health was the most common disability reported, which was listed in 31% of all cases. This was followed by long term illness health condition (13%), learning difficulty (6%), mobility physical (5%), physical disability (3%), blind/visual impairment (1%), and deaf/hearing impairment (1%). Another 8% of cases did not disclose whether they had any disabilities. Further information relating to mental health is also recorded under risks and issues which includes a breakdown of specific mental health issues (for more information see 5.2 Assessment).

As previously mentioned, research suggests that the collection of data relating to the protected characteristics of victims is limited, varying in completeness and accuracy across organisations (The Centre for Justice Innovation, 2023). Findings from this dataset align with the wider literature as seen in Figure 5.3, which shows the total number of cases within the sample that have missing data. There is variation of completeness, with missing values ranging across the nine characteristics from 0.01% for gender to 22% for religion.

Figure 5.3: Count of missing values



Base = 6,457

Figure 5.3 covers all cases in the dataset, with start dates between June 2001 and May 2023.

A report published by His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (2023) found that in police recorded crime data between 2021–22 the victim's ethnicity was missing in 61% of records, sex was missing in 26%, and age in 27% of records. The findings shown in figure 2 suggest that overall, SWERCC have well completed protected characteristics data in comparison to the police.[29] However, even within a service who prioritise high quality data collection, data on protected characteristics may be incomplete meaning that bespoke, detailed research into marginalised groups is challenging.

Furthermore, it highlights the issue of inconsistent data collection of key variables such as disability across organisations. The SWERCC dataset includes multiple measures of

[29] This research illustrates how data relating to protected characteristics can often be missing. It is not intended as a direct comparison due to differences in the way protected characteristics are recorded. For example, SWERCC record gender and police record sex.

mental health, which is recorded by the service as a disability. A victim-survivor may not self-report that they have a disability initially in the protected characteristics measure, but as previously mentioned may go on to disclose symptoms of mental health at the assessment stage in risks, issues, and impacts. This makes it challenging to compare or identify trends on a wider scale, both within this dataset and between organisations.

From a research perspective, accurate and complete data relating to protected characteristics is important to carry out meaningful analysis, exploring disproportionality and barriers to access that marginalised groups face. It creates the opportunity to improve services for victims of crime based on evidence and data-driven decisions. However, when considered from a victim-survivor's perspective, the suggestion that they may not be comfortable or wish to not share this information should not be overlooked.

The findings from this data suggest that victim-survivors are more willing to share some aspects of their personal information than others. For example, whilst they are willing to share their age, they may not be comfortable to share their religion or sexuality. A survey carried out by the Victims' Commissioner (2020) found that of those who did not report to the police, 88% felt their gender, sexuality or lifestyle would result in their incident not being investigated and/or prosecuted successfully. Whilst it should be considered that this research is based on a small sample size of 491 participants, these findings are supported by further literature. Further research suggests that victim-survivors with protected characteristics fear being misunderstood, treated insensitively, turned away, and discriminated against by support providers which deters them from seeking support (Silk, 2023). Due to this, a victim-survivor may want to withhold personal information if they do choose to seek support, or they may feel that information is irrelevant to their support needs. From a service provider's perspective working to build trust with the victim-survivor, it may not be appropriate to ask or push for this information.

Whilst research shows that rape and sexual violence are crimes that disproportionately impact younger women, it also shows that anybody can be a victim of rape and sexual violence. CSEW for the year ending March 2022 estimates that approximately 26% of those who experienced sexual assault (including attempts) in the last year were male.[30]

[30] Sexual offences victim characteristics, England and Wales - Office for National Statistics (ons.gov.uk)

A literature review exploring the formal support needs of adult victim-survivors of sexual violence identified multiple barriers to access that are faced when seeking support. Those with protected characteristics reported barriers such as a fear of not being believed by service providers and a lack of understanding of what sexual violence is and who it affects (Silk, 2023). As a result, it is essential that all victim-survivors can access quality services that meet their needs. However, to achieve this, it is essential that policymakers have high-quality data on protected characteristics to ensure that policy decisions intended to improve outcomes are based on robust, data-driven evidence.

The Thinks Insight & Strategy, formerly known as BritainThinks (2021) report explores why the public may not be willing to share their data and what may encourage them to do so, as discussed in the data landscape section of this report. However, research could be carried out with victims and practitioners to gain a better understanding of how to improve the collection of protected characteristics within support services. Alongside this, research into how service uptake and engagement by marginalised groups can be improved could be beneficial to enhance the current evidence base and inform policy decisions on commissioning of services.

Crimes experienced by victim-survivors who are referred

Victim-survivors may have experienced multiple incidents and all incidents disclosed to SWERCC are recorded. The primary incident is defined as the incident which led them to seek support.

Over half of all cases have a primary incident of rape, making this the most common within the dataset (52%). Child sexual abuse is the second most common primary incident accounting for 27% of cases. This is followed by sexual violence (11%), and sexual exploitation (1%).[31] 'No incident' accounts for 8%, which are cases that relate to secondary victim-survivors.

Of all individuals, most victim-survivors who attended the service stated that they had experienced one type of incident (78%). The remaining stated that they had experienced

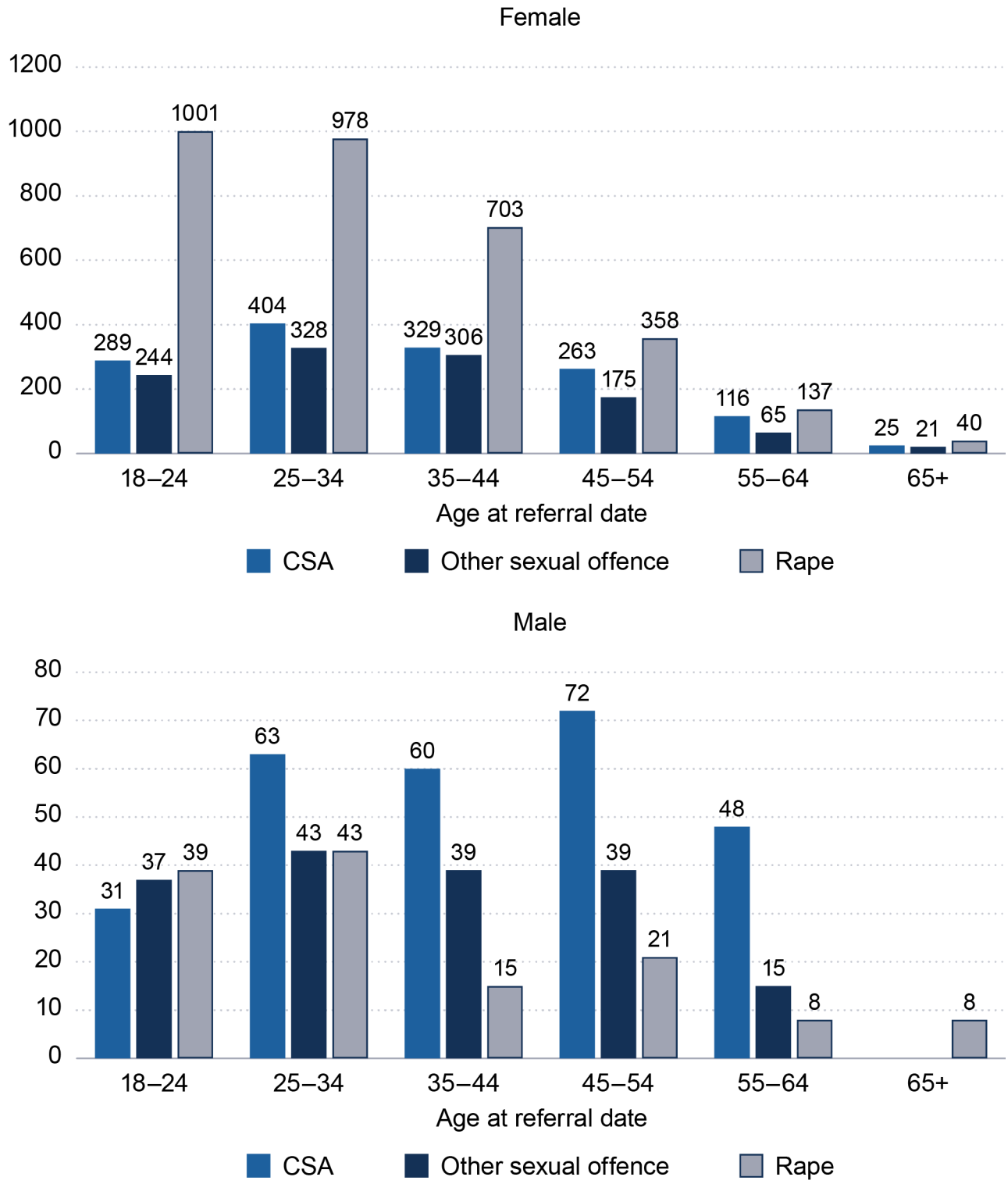
[31] Primary incidents also include domestic violence (0.2%) and stalking and harassment (0.2%).

multiple incidents (22%) or no incident (0.4%). No incident relates to secondary victim-survivors.

Of those who experienced one type of incident, 29% said that this had happened once, 16% were unknown and 18% had missing data. The remaining 37% stated that they had experienced the incident type multiple times. This suggests that a large proportion of victim-survivors within the dataset are repeat victims.

When primary incidents are broken down by gender and age, differences can be seen in the type of primary incidents that are experienced. Figure 5.4 shows that for females, rape is the most common primary incident amongst all age groups, whereas males are more likely to have a primary incident of CSA in almost all age groups. Although the limitations associated with the small sample size of males within the data should be considered when interpreting this finding, this could be explored through further research to identify if this is true for other sexual violence support services in England and Wales.

Figure 5.4: Count of victim-survivors by primary incident, age, and gender



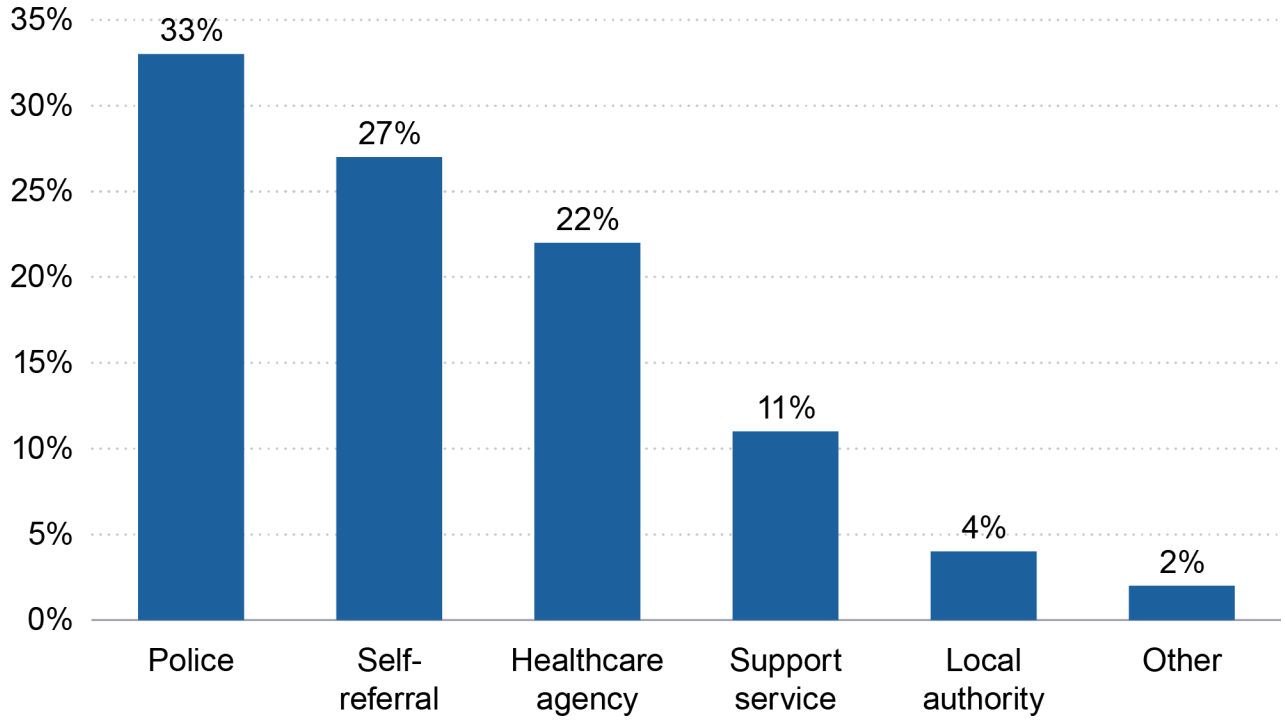
Base = 6,366

Figure 5.4 covers all cases in the dataset, with start dates between June 2001 and May 2023, where age was supplied, and gender was male or female. Cell counts fewer than three have been supressed.

How victim-survivors are referred to the service

Victim-survivors can be referred to the service in various ways. They can self-refer, be referred by a statutory or voluntary organisation, or by somebody that they know. Figure 5.5 shows the total percentage of referrals into the service from each referral source.

Figure 5.5: Proportion of all cases by referral source



Base = 6,451

Figure 5.5 covers all cases in the dataset, with start dates between June 2001 and May 2023, where referral source was supplied.

The police are the most common source of referrals into the service (33%). Almost all of these are from Essex Police, which account for 97% of police referrals. The individuals referred by the police most commonly have a primary incident of rape (72%), followed by CSA (15%).

The Victims' Code[32] sets out what criminal justice agencies (including the police) must do for victims and the timeframe in which they must do it. This includes the responsibility of referring victims to suitable support services that are tailored to their needs. As part of the police pathway model[33] used by SWERCC, all rape cases reported to Essex Police are referred into the service within 24 hours with the victim-survivor's consent. This ensures that victim-survivors are offered support and allows the service to offer initial holding support and early interventions when police are not immediately able to allocate an officer in charge of the case.

As the police are most commonly the first criminal justice agency to engage with victims, when considering the police pathway model and victims' code requirements it would be logical to initially expect that most referrals into the service would be police referrals. However, despite police referrals being the most common referral source, they do not make up the majority, with 67% of referrals received from other sources.

Self-referrals are the next most common referral source, making up 27% of referrals. For self-referrals, 37% of victims had a primary incident of rape, and 33% had CSA.

This is followed by referrals from healthcare agencies (22%). Sexual Assault Referral Centres (SARC) are the most common type of healthcare agency that refer into the service, making up one third of all healthcare referrals (33%). This is followed by mental health (25%) and Improving Access to Psychological Therapies (IAPT) (19%). Referrals from SARC predominantly have a primary incident of rape (85%). This is compared to mental health and IAPT referrals which are most commonly for CSA cases. Over half of all IAPT referrals are for CSA (61%), as well as half of all mental health referrals (51%).

Other support services also refer into SWERCC (11%). Domestic violence services are the most common type of support service, making up 23% of support service referrals. This is closely followed by other rape crisis centres (20%).

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[32] Code of Practice for Victims of Crime in England and Wales (Victims' Code). The Code of Practice for Victims of Crime in England and Wales and supporting public information materials - GOV.UK (www.gov.uk)

[33] As part of the police pathway model, all rapes reported to Essex Police are referred to SWERCC within 24 hours of report, if the victim-survivor gives consent.

According to previous research, referral sources vary depending on the support service sector. It is suggested that victims are more likely to self-refer and be willing to engage with third sector organisations due to their independence from statutory organisations such as the police and healthcare, with national support service monitoring data supporting this concept (Robinson & Hudson, 2011). Further research also suggests that referral source may influence a victim's willingness to engage with specialist third sector support services (Bunce, Blom, & Capelas Barbosa, 2024).

Despite the limited research in this area, these findings highlight the importance of the relationship between referral source, victim perception of referral source, and their engagement with support services. Further research which examines why most victim-survivors are referred by non-police sources could be beneficial. For example, could it be explained by a lack of compliance to the victim's code with police not offering support or making the necessary referrals, that those who were referred by other organisations never reported the crime, or that victims did not give consent to be referred by the police. Understanding these concepts could improve the current evidence base on compliance with the victims' code, alongside factors that impact victim engagement with the police, support services and other organisations such as healthcare agencies. Furthermore, developing an understanding what victims need and want from organisations who refer could support the identification of the most appropriate referral pathways.

5.2 Assessment

Once a referral has been received, a First Contact Navigator will make initial contact with the victim-survivor to arrange a suitable time for a needs assessment to be carried out. The First Contact Navigator team are all specially trained to work with victims of sexual violence and child sexual abuse and will provide guidance and information relating to the services available in the local area, helping to access the right support, at the right time. As the referral form only includes minimal information, the assessment is the stage where more detailed data is collected.

The aim of the assessment is to develop an understanding of the person, focusing on what they are thinking, feeling, seeing, hearing, saying, and doing. This information allows the service to build a programme of support that best addresses the risks and needs

presented by the victim-survivor to support them to cope and build resilience. The questions that are asked focus on a broad range of domains that support this such as mental health and psychological wellbeing, risks and issues, safeguarding, employment, education, and finance.

It is important to note that not all questions in the assessment are mandatory. Depending on the circumstances, some questions may be deemed inappropriate in the initial meeting. As this is the first formal interaction between SWERCC and a victim-survivor, some information may be left blank at assessment stage and revisited at a more suitable time in the victim-survivors journey.

Risks, issues, and impacts

The risks, issues and impacts that are presented by victim-survivors are recorded as separate data fields in individual lists that cover a wide range of topics.[34] They are collected during the assessment stage of the journey. However, if a victim-survivor discloses further information after an assessment they can be added at any point up until a case is closed. Although they are independent fields in the data, there is some overlap between the three due to their nature. For example, the impacts can lead to issues, which then put the victim-survivor at risk.

To differentiate, a risk is something that practitioners should be aware of, such as areas of concern that may cause harm to the victim-survivor. An issue is a current ongoing problem that practitioners need to be aware of and may need addressing. This data does not explicitly state whether the issues and risks presented by a victim-survivor are a result of the incident. It does provide valuable insight into the needs and problems experienced by those who attend the service. The incident impacts however can be attributed to the incident and provide valuable insight into the effect of sexual abuse and rape on those who enter the service. This can include symptoms, feelings or situations that have happened because of their experience of sexual violence.

Cases can present with more than one risk, issue or impact and are self-reported. Table 5.1 shows that most victim-survivors attend the service with multiple issues (69%)

[34] There is a total of 49 risk, 92 issue, and 91 impact data fields listed within the dataset. See Annex 3.

and impacts (68%) highlighting the profound impact of sexual violence and complexity of support required.

Table 5.1: Count of risks, issues and impacts present

	Risks	Issues	Impacts
Multiple	18%	69%	68%
One	45%	23%	21%
None/none currently known	26%	2%	1%
NA/not able to obtain	11%	6%	10%

Base = 6,457

Tables 5.2, 5.3 and 5.4 show the most reported risks, issues, and impacts within the dataset. Cases can present with more than one, issue or impact and are self-reported. These findings highlight that victim-survivors most commonly attend the service with needs relating to poor mental health and psychological wellbeing.

Table 5.2: Five most Common Types of Risks[35]

	Total number of cases	Total percentage of cases
At risk of mental illness	1,075	17%
Low risk	917	14%
At high risk of mental illness	629	10%
Risk of self-harm	433	7%
At high risk of domestic violence	394	6%

Base = 6,457

Table 5.3: Five most Common Types of Issues

	Total number of cases	Total percentage of cases
Post trauma symptoms	3,173	49%
Anxiety	1,877	29%

[35] Within the risk data fields, there are broad categories such high, medium, low, and no risk included. It does not specify what the victim-survivor is at risk of. There are also distinctions made between levels of risk such as 'at risk' and 'at high risk'.

	Total number of cases	Total percentage of cases
Mental health present[36]	1,511	23%
Diagnosed – Depression	1,463	23%
Diagnosed – Anxiety	1,291	20%

Base = 6,457

Table 5.4: Five most Common Types of Incident Impacts

	Total number of cases	Total percentage of cases
Post trauma symptoms	3,740	58%
Anxiety	3,499	54%
Depression	2,478	38%
Sleep problems	1,739	27%
Low mood	1,717	27%

Base = 6,457

Poor mental health and psychological wellbeing needs are most common amongst all cohorts within the data. However, there are some notable differences in the prevalence of risks, issues and impacts presented in different groups.

For example, a risk of mental illness is more prevalent amongst older age groups. A quarter (25%) of cases for victim-survivors in the 18- to 24-year-old age group had a risk of mental illness, compared with nearly a third (32%) of 55- to 64-year-olds. The same is found for the recorded issues relating to mental health, where post trauma symptoms were reported more frequently in the older age groups. In around half of cases for 18- to 24-year-olds (48%) post trauma was listed as an issue. This compares with 61% of 65–74-year-olds.

When looking at primary incidents, anxiety was noted as an impact more often for victim-survivors with a primary incident of CSA (63%) than those with a primary incident of rape (53%). The same pattern was present with depression, where one in two victim-survivors

[36] Present means that it is currently an issue. There are multiple data fields that provide further context to highlight if an issue is past or present. For example, 14% of cases have a history of domestic violence and 4% have a current domestic violence issue.

of CSA reported depression as an impact (50%) compared with two in five (38%) victim-survivors of rape.

For victim-survivors who waited more than two years to seek support, mental illness as a risk was noted at a higher rate (31%). This compares to a quarter of cases where the victim waited less than a week (24%), and a fifth where they waited between a week and a month (21%).

Just over one tenth (11%) of cases had self-harm listed as a risk. This was seen at a higher rate in younger groups. A total of 16% of cases linked to 18- to 24-year-olds were listed as a self-harm risk, compared to every group over 35 years old which were all one tenth or less (<11%).

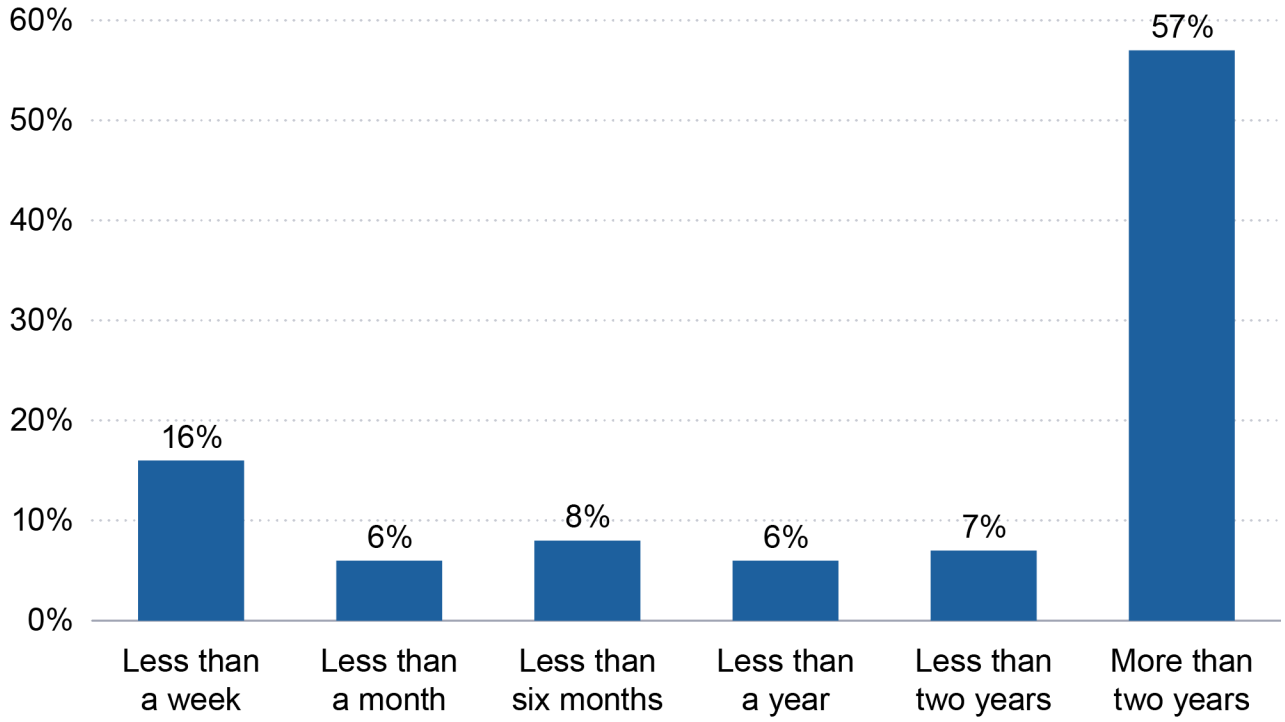
The risk of domestic violence was more prevalent in those that lived with their children (20%) compared with those that live alone (12%). Furthermore, it was more prevalent in younger age groups with 15% of both 18- to 24-year-olds and 24- to 34-year-olds stating this as a risk. This compares with 6% of 55- to 64-year-olds. Nearly one fifth (18%) of cases with a primary incident of rape had domestic violence stated as a risk, compared with 4% of CSA cases.

Although these findings need to be treated with caution due to the small sample size of certain cohorts within the data such as older individuals, it highlights that the data does include the level of information required to identify differing needs amongst victim-survivors. This could be tested on a larger scale to support assessments of demand for tailored support.

Time elapsed before seeking support

Victim-survivors can access support from SWERCC regardless of when the incident took place. Taking the step to access support can take some victim-survivors much longer than others. This can be due to a variety of reasons identified from anecdotal evidence and can depend on when they feel ready. This includes barriers to access identified in the wider literature such as fear, a lack of awareness of support services, their relationship with the perpetrator and fear of the criminal justice process. Data is collected that shows the amount of time between the incident taking place and a victim-survivor accessing support.

Figure 5.6: Time elapsed between primary incident and seeking support



Base = 5,903

Figure 5.6 covers all cases in the dataset, with start dates between June 2001 and May 2023, where time elapsed before seeking support was supplied.

Figure 5.6 shows that over half of all victim-survivors waited more than 2 years before seeking support (57%). This is followed by 16% of those who waited less than a week. The total number of cases for the other timeframes is considerably less.

Waiting over two years was found to be most common amongst all primary incidents. It was also the case for all genders and age groups. A total of 50% of females and 68% of males waited more than two years. Furthermore, 41% of cases with a primary incident of rape and 93% of cases with a primary incident of CSA waited more than two years. Overall, it was most prevalent amongst males and those with a primary incident of CSA. However, it should be considered that the total number of males in the sample is considerably less than females and the large proportion of CSA cases that waited more than two years may be explained by those under 18 being excluded from the data share.

There were also differences in the length of time before victim-survivors sought support depending on the referral source. For victim-survivors who were referred by the police,

41% waited over 2 years before reaching out to seek support, compared with 64% of self-referrals.

For those who are referred to the service soon after the incident, the referrals are most likely to come from the police or a healthcare agency. It might be that victim-survivors engage with these organisations soon after the incident and therefore have a quicker referral and more rapid access to support services. For example, through the police pathway model where victim-survivors are referred within 24 hours of reporting, or SARC where forensic examinations are carried out.

Support network

Data is also collected on a victim-survivor's support network. This includes information such as whether a victim-survivor felt that they received a supportive reaction in relation to the incident from family and friends. The most common reaction reported was mixed, which was reported in one third of all cases (33%). In one in four cases, victim-survivors said they received a supportive reaction (25%). An unsupportive reaction was received in 7% of cases, and a further 1% said they received no support. There were also some who had not disclosed the incident to family or friends (11%).

Data on a victim-survivor's living situation is also collected. Victim-survivors living with their family (40%), or partner and children (35%) were most likely to receive a supportive reaction. This is much less for victim-survivors who live alone, with one fifth stating that they had received a supportive reaction (18%).

Primary perpetrator

According to CSEW year ending March 2020, almost 1 in 2 rapes against women are carried out by their partner or ex-partner (45%), and 5 in 6 rapes against women are carried out by someone they know (86%).[37] The SWERCC data aligns with the wider literature. Within this sample, 45% of cases with a primary incident of rape have partner or ex-partner as the primary perpetrator. A total of 81% of all cases said the perpetrator was someone they know.

[37] Nature of sexual assault by rape or penetration, England and Wales - Office for National Statistics (ons.gov.uk)

A review of existing literature based on international evidence revealed that victims who knew the perpetrator were less likely to acknowledge their experience as sexual violence and seek formal support (Zinzow, Littleton, Muscari & Sall, 2021). Further research also highlights that if the victim had previously engaged in consensual sexual activity or were in a relationship with the perpetrator that they were less likely to realise or accept that they had been raped (Champion et al., 2021). These findings highlight the potential implications of the victim-offender relationship and impact it may have on engagement with sexual violence support services. Further research on a larger scale to explore the impact of such relationships on engagement with support services could be beneficial.

Employment and finance

There is also data relating to a victim-survivor's employment status and finances. Whilst this data is limited, it does mean that certain groups such as students and those from low-income households can be identified.

One third (33%) of the cases in the dataset had an employment status of unemployed. A further one third (33%) were employed and 3% were self-employed. The CSEW year ending March 2022 found that in the last year, a higher proportion of full-time students were victims of sexual assault than those in any other occupation type (10%).[38] In the SWERCC dataset, 6% of cases stated that they were a student.

The data includes a breakdown of financial situations ranging from different types of benefits to pensions. Within the sample, 28% of all cases stated they were not in receipt of any form of benefit. Nearly one fifth (18%) received Universal Credit and 15% received child benefit. In total, 58% of cases stated they were in receipt of at least one benefit.

Overall, the data that is collected during the assessment stage allows the service to gain deeper insight into the needs and risks of victim-survivors, building a fuller picture of the victim-survivor's circumstances and providing the opportunity to deliver more tailored wraparound support. It also provides improved safeguarding opportunities.

[38] Sexual offences victim characteristics, England and Wales (ons.gov.uk)

From a data linking perspective, the data collected by SWERCC provides invaluable insight that is often missing from CJS data. The information collected relating to victim-survivor risks, issues and incident impacts creates the opportunity to gain an understanding of victim-survivor needs. It could also create the opportunity to better understand how needs and characteristics may impact victim attrition from support services and the CJS. Furthermore, this is both true for CJS and support services which could potentially provide a more holistic view if linked to other organisations data such as health or local authority data.

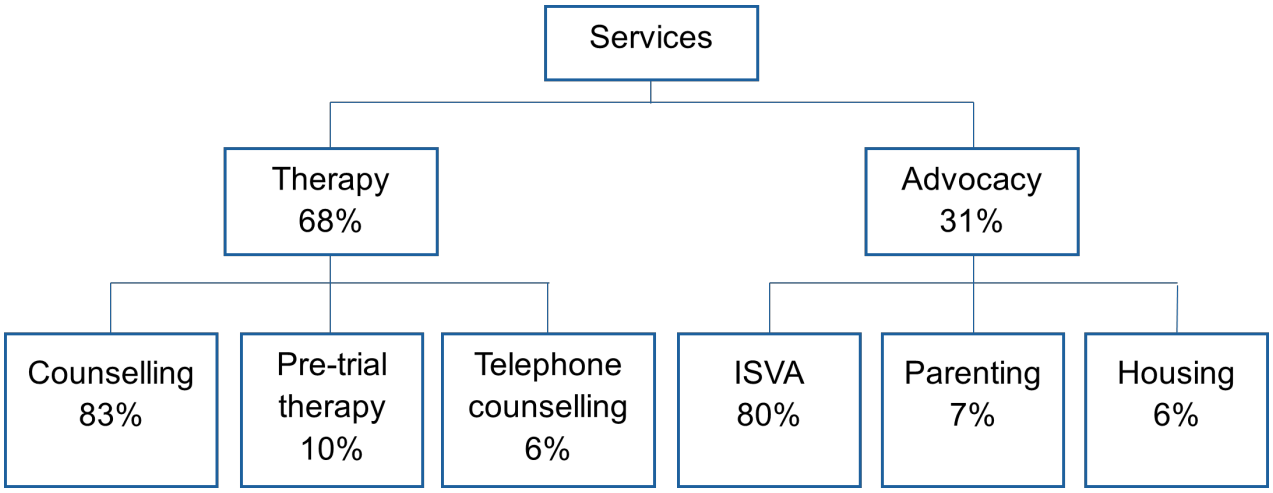
5.3 Services

After an assessment is completed, a support plan is agreed between the service provider and victim-survivor. It includes allocation to one or more specialist services and is tailored to meet needs and risks depending on an individual's circumstances. Additional services can also be added at any time before a case is closed.

The services that are offered

This section of the report focuses on the services that SWERCC offer; it does not show how many victim-survivors disengaged or completed a service (see service engagement). SWERCC offers a wraparound service which entails the offer of multiple types of support. It allows a victim-survivor to access different services that address many different needs, all in one place, at the same time. As victim-survivors can have multiple services for each case, service level data has been analysed. This includes 6,499 services which have been offered to all cases including open and closed cases.

Figure 5.7: Services offered[39]



Base = 6,449

The two most common services offered by SWERCC are therapy (68%) and advocacy (31%).

Therapy includes services that focus on emotional support. This can range from ensuring a person feels emotionally supported through the CJS process, to learning positive coping strategies to improve wellbeing and build resilience. Of all therapy services, counselling (83%) is the most common, with a further 6% which are telephone counselling sessions. Pre-trial therapy is the next most common service, accounting for 10% of therapy services.

Advocacy includes providing emotional and practical support on a range of issues a victim-survivor may be facing. It involves representing their views, needs and rights and acting on their behalf, ensuring they have clear information to help them make informed decisions. Of all advocacy services offered, most are in the form of an ISVA (80%). ISVAs support victims-survivors who have reported to the police or are considering reporting to the police. They play a critical role in helping to navigate the criminal justice process and provide support before, during, and after a trial.

[39] Services which are rarely used have been excluded from this figure. This includes groups (1%), helpline (0%) and outreach (0%) services. Therapy services not included are emotional support (2%), body work (0%), email counselling (0%), play therapy (0%), and telephone support (0%). Advocacy services not included are financial (3%), other legal (2%), health (1%), education (1%), employment and training (1%), DV related (0%), children's ISVA (0%), keep safe work (0%), immigration (0%), and prostitution (0%).

To understand the uptake of the wraparound service that SWERCC offer, closed cases have been analysed to illustrate how many victim-survivors access only one type of service (therapy or advocacy) versus multiple services. Services can be added to a case at any point up until a case is closed. This means that open cases with only one service may have other services added in the future. Therefore, analysis of services offered to closed cases will provide the most accurate insight.

Of closed cases, 38% have therapy only listed as a service, 20% have both therapy and advocacy listed, and only 5% have advocacy only. The remaining 37% were not offered a service as they disengaged before this stage of the journey. These findings suggest that the two most common support plans either include therapy only; or both advocacy alongside therapy.

Therapy is the most offered standalone service for all primary incidents. Approximately 2 in 5 people who passed the assessment stage were only in need of or wanted to access therapy (38%). This is most common amongst CSA cases (55% of CSA cases only accessed therapy, compared with 30% of rape cases). There could be a hypothesis made that the higher uptake of therapy as a standalone service amongst victim-survivors could be due to many victims not reporting the crime that happened to them to the police, as advocacy support is only required for victim-survivors who do report or are considering reporting. Further research or data collection that explores why victim-survivors access certain services could be useful to understand this further. It would also provide insight into victims who report to the police versus victims who do not.

Approximately 1 in 5 of all victim-survivors that passed the assessment stage needed or wanted to access both therapy and advocacy (20%). The use of the wraparound service is most common amongst rape cases (24% compared to 16% of CSA cases). This could be due to cases with a primary incident of rape often being more likely to be actively involved with the CJS, therefore requiring advocacy support. For example, 78% of all rape cases were reported to the police compared with 52% of all CSA cases. Police referrals are also higher for rape cases (46%) than CSA cases (18%) which suggests increased police involvement in rape cases amongst adults. It may also be explained by the increased

government funding set out in the Rape Review progress update which aims to increase the number of ISVA/IDVAs by 43% by 2024/25.[40]

This data helps to build an understanding of how services are being offered and what services are most needed by victim-survivors. As a result, it creates the opportunity to ensure that data-driven policy decisions are made when considering how to fund sexual violence support services and better tailor support that best meets the needs of victims. Although these findings cannot be generalised due to the small sample size, it highlights the potential benefits of exploring this concept on a larger scale. This could include exploring uptake of other services such as group support, peer support, and practical support amongst other third sector support services.

Waiting lists

If the demand for services is in excess of the provision available, then victim-survivors are more likely to be placed on a waiting list. Those who require therapy are likely to be placed on a waiting list. Over half of all cases that require advocacy can access the service immediately with no waiting list (65%), compared with only 9% for those who require therapy.

The average number of days spent on a waiting list is also longer for therapy (83 days) than advocacy (51 days). Most victim-survivors wait 100 days or less for an advocacy appointment (85%). This compares with 63% of victim-survivors waiting 100 days or less for a therapy appointment.

The benefit of the wraparound service that SWERCC offer is that the ability to access multiple services means if placed on a waiting list, other support can be accessed in the meantime. For example, if a victim is placed on waiting lists for both therapy and advocacy, on average they will wait 40 days for their first appointment. If a victim is placed solely on a waiting list for therapy, on average they wait 85 days for their first appointment. This will vary depending on the type of advocacy and therapy required, and a first appointment may be arranged much sooner.

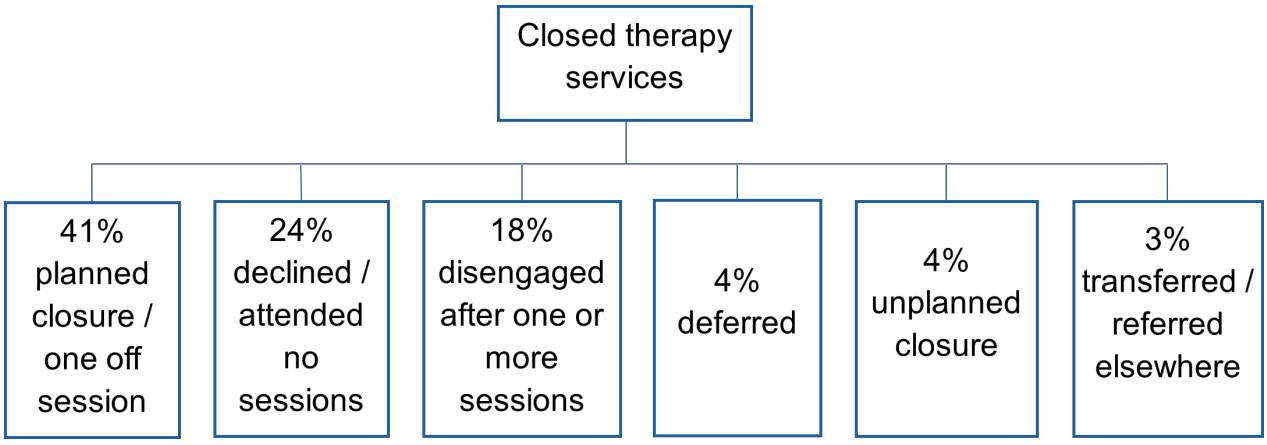
[40] End to End Rape Review Progress Report - GOV.UK (www.gov.uk)

Waiting lists can be impacted by multiple factors such as funding, demand, and capacity within services. The national picture of waiting lists across support services in England and Wales is not understood due to lack of available data. There are no benchmarks to understand the average length of waiting lists, or evidence to identify best practice amongst services to reduce waiting lists and effectively meet demand. The Women and Girls Network estimate that their waiting list for ISVA support may be approximately 3–6 months,[41] which demonstrates how each service's waiting list will vary depending on many factors.

Service engagement

When each service ends a closure reason is recorded. This can be used to understand which victim-survivors completed the service as planned and services that ended in an unexpected closure. There are multiple reasons recorded that suggest why a victim-survivor may have had an unexpected service closure (see Annex 2). The reasons listed within the data are vague. However, they do indicate which services have the highest and lowest attrition rates.

Figure 5.8: Therapy service closure reasons[42]

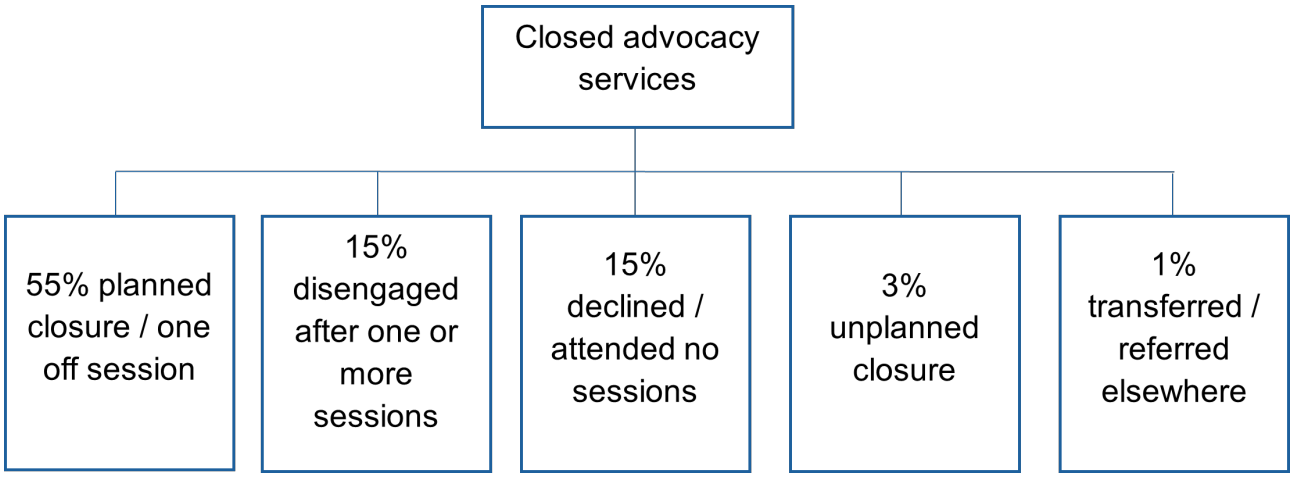


Base = 4,100

[41] Independent Sexual Violence Advocate (ISVA) | Women and Girls Network (wgn.org.uk)

[42] The remaining 6% of closed therapy services had no closure reason listed (NA).

Figure 5.9: Advocacy service closure reasons[43]



Base = 1,754

In over half of all advocacy support offered, the victim-survivor engaged and ended the service in a planned way (55%). The planned closure rate of therapy is lower, with 41% of services ending with a planned closure. These findings reveal that victim-survivors are more likely to engage with advocacy. It is not possible from the data to understand why therapy services have higher attrition rates, and this work could be followed up with qualitative research to gain further insight into why victim-survivors disengage. For example, this could be due to the service being inappropriate, poor experiences, or because the service does not meet victim-survivor needs. This could allow for service design improvements to enhance engagement and ensure that the service effectively meets needs.

For advocacy, the remaining 45% ended with an unexpected closure. Of all advocacy services, 15% ended with victim-survivors who attended one or more appointments but did not finish the service as planned. This is followed by individuals who attended no appointments or declined the service (15%).

For therapy, the remaining 59% ended with an unexpected closure. Of all therapy services, 24% ended as victim-survivors attended no appointments or declined the

[43] The remaining 10% of closed advocacy services includes 9% which had no closure reason listed (NA). The remaining 1% is made up of those which equal less than 0.5% each, which have not been included due to the small number of individuals.

service. This is followed by individuals attended one or more appointments but did not finish the service as planned (18%).

'Deferred' is an unexpected closure reason that is predominantly listed for therapy services accounting for 4%, compared to only 8 services that were deferred for advocacy. This is where a service is temporarily paused. This higher prevalence of deferred outcomes in therapy could be explained as an impact of COVID-19, as whilst advocacy services continued face-to-face, some individuals who did not want to receive online therapy chose to pause their service.

There is no further data available within this dataset to provide insight into specific reasons for unexpected closures; however, it is possible that this could have been detailed in free-text fields which were excluded from the data share to protect personal identifiable information. Data collection of more detailed reasoning that is not recorded in free text fields could be beneficial in the future.

Before and after questionnaire

The after questionnaire includes the same questions as the before questionnaire and is used to measure improvement in a victim-survivor's wellbeing after engagement with the service. Most cases with an after questionnaire recorded are for those with a planned closure. There are very few recorded for those with an unexpected closure; this includes cases where the victim-survivor has engaged with a large proportion of the support programme but disengaged before completion.

It is important to note that this is the only measure within the data for assessing the impact of services on a victim-survivor's wellbeing, and ability to cope and recover. As a result, external factors that may have influenced an increased score have not been considered. However, the data suggests that if a victim-survivor stays in the service long enough to engage with the specialised support and complete an after questionnaire, it is likely that they will report improved scores.

There are eight questions included in the questionnaire. They are divided into three categories, asking if they i) feel in control of their lives, ii) feel happy about their health and wellbeing, and iii) feel able to develop and maintain positive relationships with people who

matter to them. The choice of answer ranges from strongly disagree (score of 1) to strongly agree (score of 4); there is no neutral score.

Table 5.5: End of service questionnaire summary

Question	Mean Score before	Mean Score After	Change in Mean	Mode Before	Mode After
I feel good about myself	1.90	2.78	0.87	2	3
I feel confident in myself	1.96	2.84	0.87	2	3
I feel in control of my emotions	1.98	2.79	0.82	2	3
I have positive coping skills/strategies for taking care of myself emotionally	2.15	3.02	0.87	2	3
I am taking good care of myself e.g. eating well, exercising	2.35	2.98	0.63	2	3
I feel able to make everyday decisions	2.74	3.27	0.53	3	3
I have people around me that I trust	2.90	3.21	0.31	3	3
I feel close to the people who matter to me	2.93	3.23	0.29	3	3

Base = 1,742

Table 5.5 shows that for those who completed both questionnaires, almost all had improved scores (85%) or the same score (7%). In 9% of cases a lower score was reported in the after questionnaire. This is shown in the above chart by the increase in mean for all 8 questions. Furthermore, for questions listed 1 – 5 the most frequent answer changes from 2 (disagree) to 3 (agree) suggesting that a victim-survivor's perception on their overall wellbeing, resilience, and ability to cope has the biggest improvement. There is less of an improvement on questions that relate to victim-survivors' relationships. Nevertheless, on average all areas increased.

Therefore, the findings suggest that for those who engage, the service has a positive impact on a victim-survivor's ability to cope and build resilience and is therefore working in the intended way.

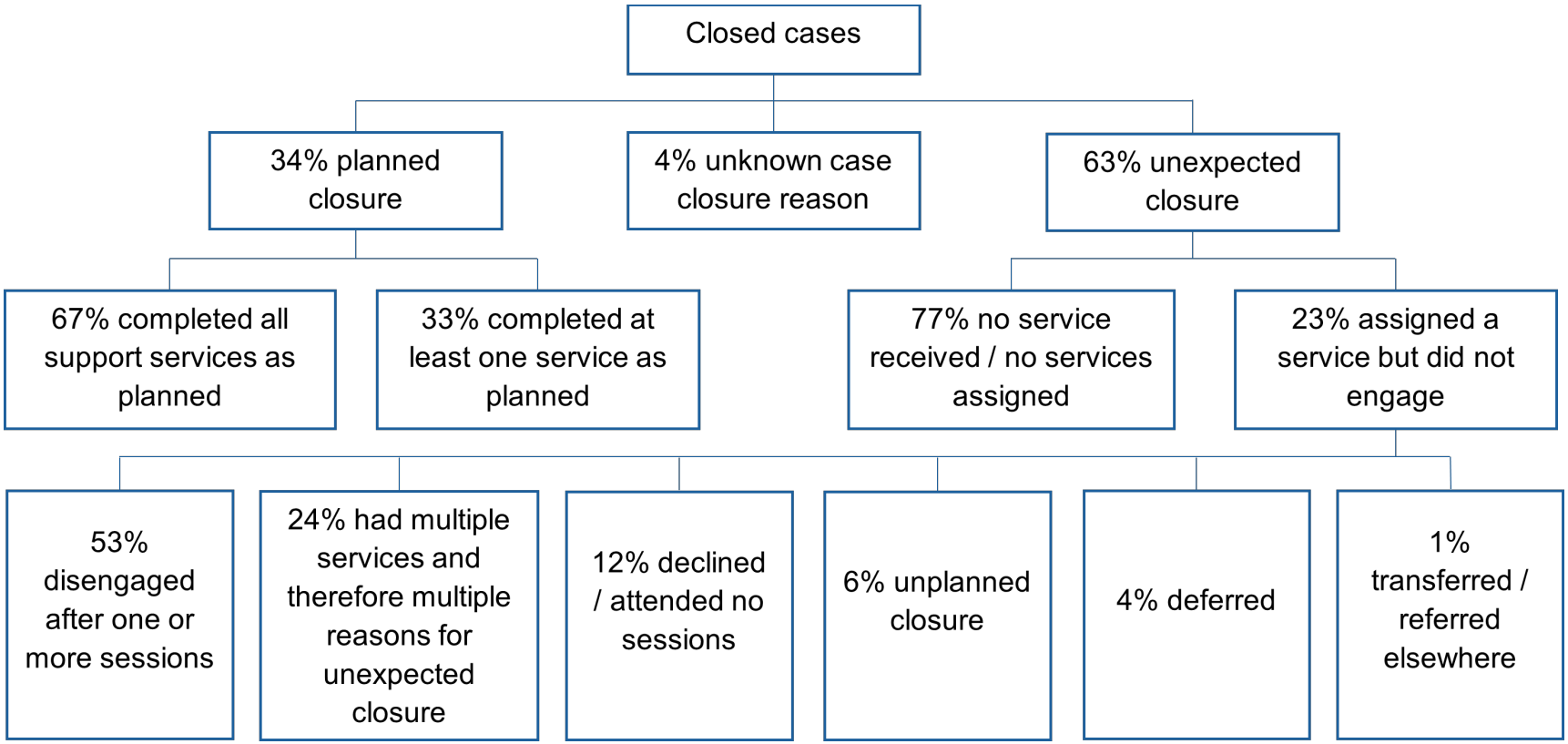
5.4 Closure

The victim-survivor journey through the support service comes to an end when a case is closed. This will happen when the programme of support and all services linked to the case have been closed.

Case closure reasons

The final case closure reason is dictated by the service closure reason. For example, if a service has a planned closure, then the case will also have a planned closure. However, this may differ for cases with multiple services. If a victim-survivor attends both therapy and advocacy and completes one of the services as planned, the case will have a planned closure. If a victim-survivor does not complete either service as planned, the case will have an unexpected closure. As previously mentioned, the closure reasons are vague (see Annex 2). There is a lack of available detailed data that explicitly states why a victim-survivor had an unexpected closure. The data does however provide insight into how many cases ended as planned and how many did not. Figure 5.10 shows a breakdown of closure reasons for all closed cases in the data.

Figure 5.10: Case Closure Reasons[44]



Base = 5,851

[44] The sum of the individual numbers does not always add up to 100% as the percentages have been rounded.

Of all closed cases, 34% of victim-survivors completed their journey with a planned closure. For those with a planned closure, 2 in 3 also completed all services in their support programme as planned (67%); whilst 1 in 3 completed at least one service as planned (33%). This highlights that most victim-survivors who have a planned closure successfully engage with all aspects of their support programme.

Over half (63%) of closed cases ended with an unexpected closure. Of these, 3 in 4 (77%) dropped out before receiving a service and had no services assigned to their case. The case closure status is no service received. This suggests that most who drop out do so in the early stages of their journey through the support service.

Victim-survivors who were assigned to a service but did not complete as planned make up the remaining 23% of closed cases with an unexpected closure. Of these, the largest group are victim-survivors who disengage after one or more sessions (53%). Further research could be carried out to explore this further. Understanding why victim-survivors disengaged could support service design work to improve engagement.

For 24% of cases who were assigned to a service but had an unexpected closure (206 cases), 2 or more services were allocated to their case and the victim-survivor did not complete any part of their support programme as planned. This means that they have multiple reasons listed for why the case had an unexpected closure. There are 61 different variations of service closure reasons which have not been included as they provide little insight due to the vague definitions and small numbers of individuals for each.

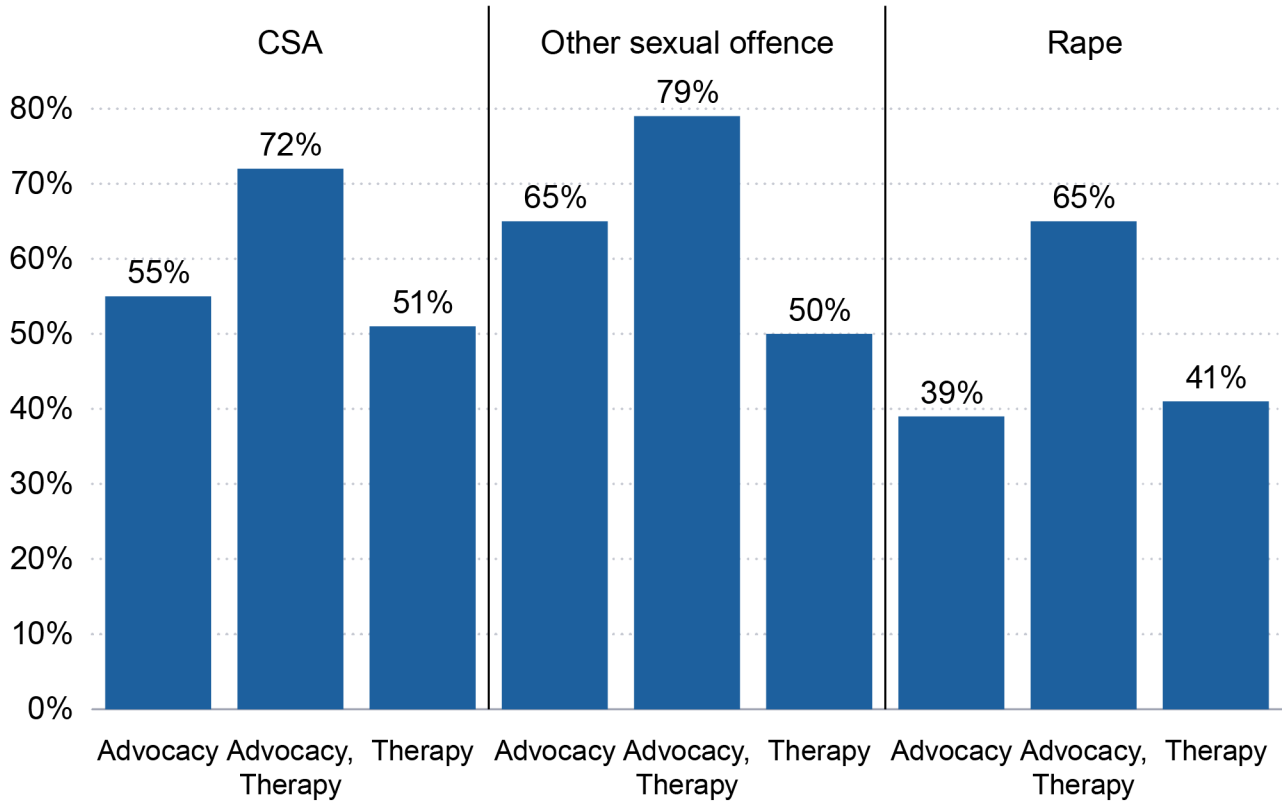
Further detail which provides insight into why a victim-survivor did not engage with the service may be included in free-text fields which is satisfactory for case-level management data and fit for purpose as the service intend to use it. As free-texts fields were not included in the data share it has not been possible to explore why victim-survivors did not engage or explore potential drivers of attrition further. However, there are potential benefits of linking this level of data to other organisations such as local level police and court data. This would provide the opportunity to explore if those who engage with the support service are more likely to engage with police investigations and support trails.

Victim attrition

The number of cases that end with a planned closure varies amongst different cohorts within the data. This suggests that some factors may influence if a case ends in a planned way. Whilst the findings cannot be generalised due to the small sample size, they provide valuable and unique insight into engagement and victim attrition within sexual violence support services that could be beneficial to explore further.

Figure 5.11 shows the total number of cases that end in planned closure amongst those who access the wraparound support compared to those who only access one type of support. Higher planned closure rates are seen amongst all primary incidents for those receiving both therapy and advocacy. It could suggest that accessing both emotional and practical support can encourage victim-survivors to engage with the service, which highlights the potential importance of services having the interventions that allow them to provide multiple types of support through one service.

Figure 5.11: Planned closure rates by primary incident and services offered



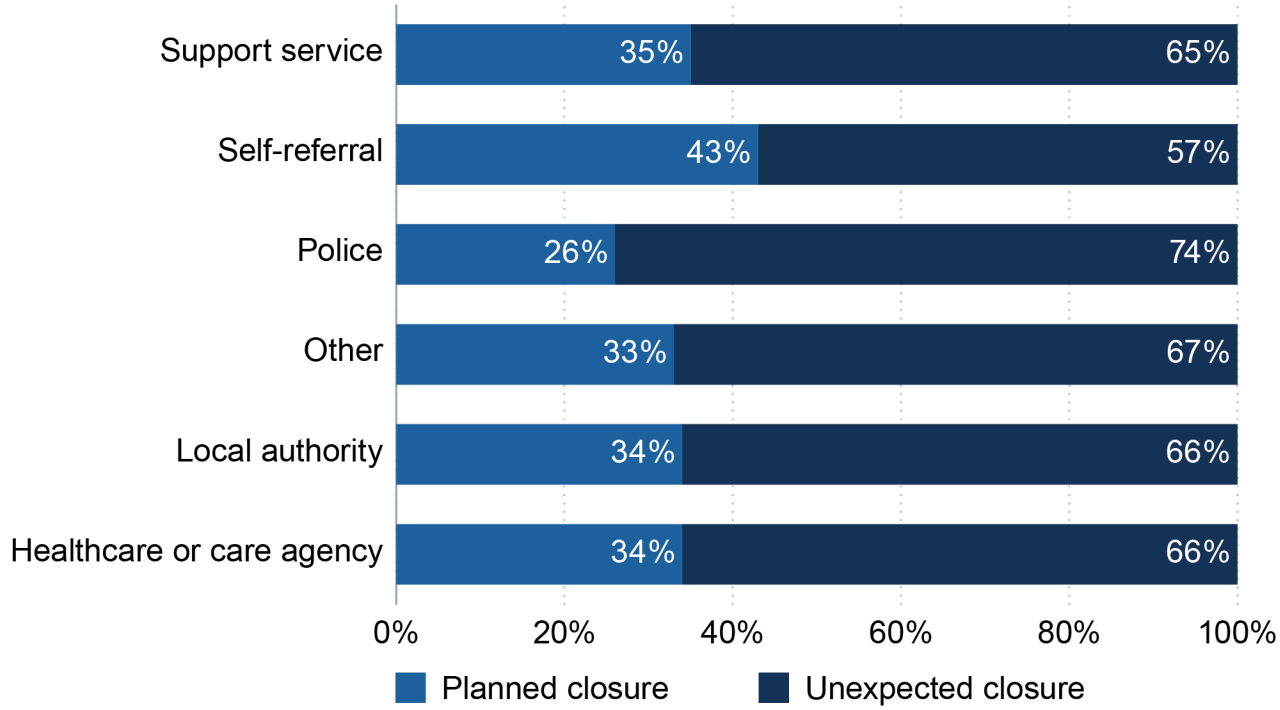
Base = 3,660

Figure 5.11 covers all cases in the dataset, with start dates between June 2001 and May 2023, where a service was offered.

Differences are also seen in planned closure rates amongst referral sources. As shown below in figure 5.12, victim-survivors who self-refer are most likely to have a planned closure. Nearly half of all victims who self-refer have a planned closure (43%), compared to only one in four victims who are referred by the police (26%). There are very small differences in prevalence of planned closure amongst other referral sources.

Robinson & Hudson (2011) found that victims who self-refer may perceive third sector organisations to be independent of statutory organisations resulting in more confidence to engage. Therefore, a hypothesis could be that those who are referred by the police may be least likely to engage as they do not view the service as independent resulting in a lack of trust. Furthermore, Bunce, Blom, & Capelas Barbosa (2024) suggest that those who self-refer are more likely to engage as they feel ready to address their trauma, which may not be the case for victims referred soon after the incident by statutory organisations. Further qualitative research that explores victims who are referred by the police but do not engage could be beneficial to understand the high prevalence of disengagement amongst this cohort.

Figure 5.12: Proportion of planned closure by referral source



Base = 5,851

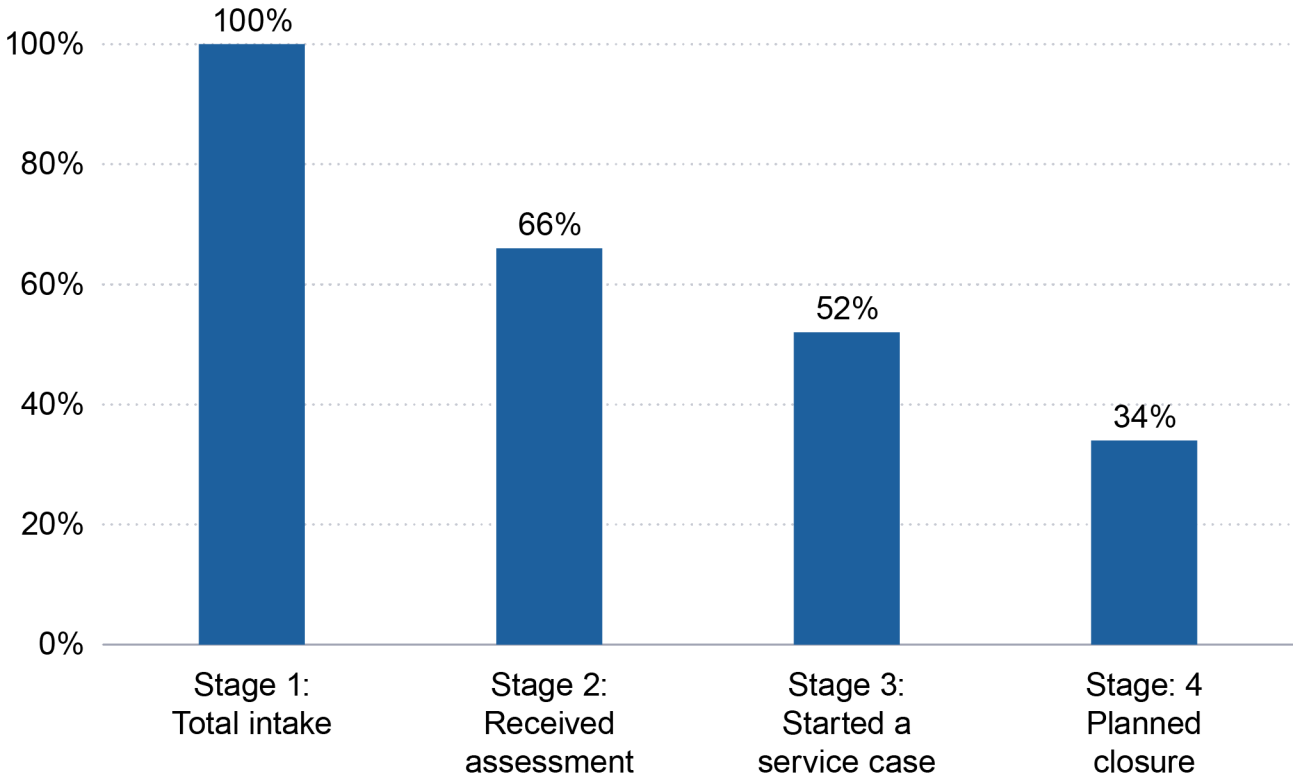
Figure 5.12 covers all closed cases in the dataset, with start dates between June 2001 and May 2023.

Prevalence of planned closures can also be seen amongst primary incident types and are highest for CSA cases. Almost half of those with CSA have a planned case closure (42%), compared to 35% of those with other sexual offences and 29% of those with a primary incident of rape.

Figure 5.12 shows the percentage of closed cases that have reached each stage of the journey, which shows when a victim-survivor's engagement with the service ends. The biggest drop off in cases is seen between stage 1 and stage 2 before an assessment is carried out, where one third of all victim-survivors disengage (34%).

Analysis of factors that may influence attrition at this stage of the journey such as information collected at the assessment stage has been carried out; however, none were identified that have proved significant in understanding who is least likely to engage with the service. It could be beneficial to explore this with a larger sample size using multiple services to provide further insight into victims who do engage vs those who do not.

Figure 5.13: Proportion of all closed cases that reached each of the subsequent stages

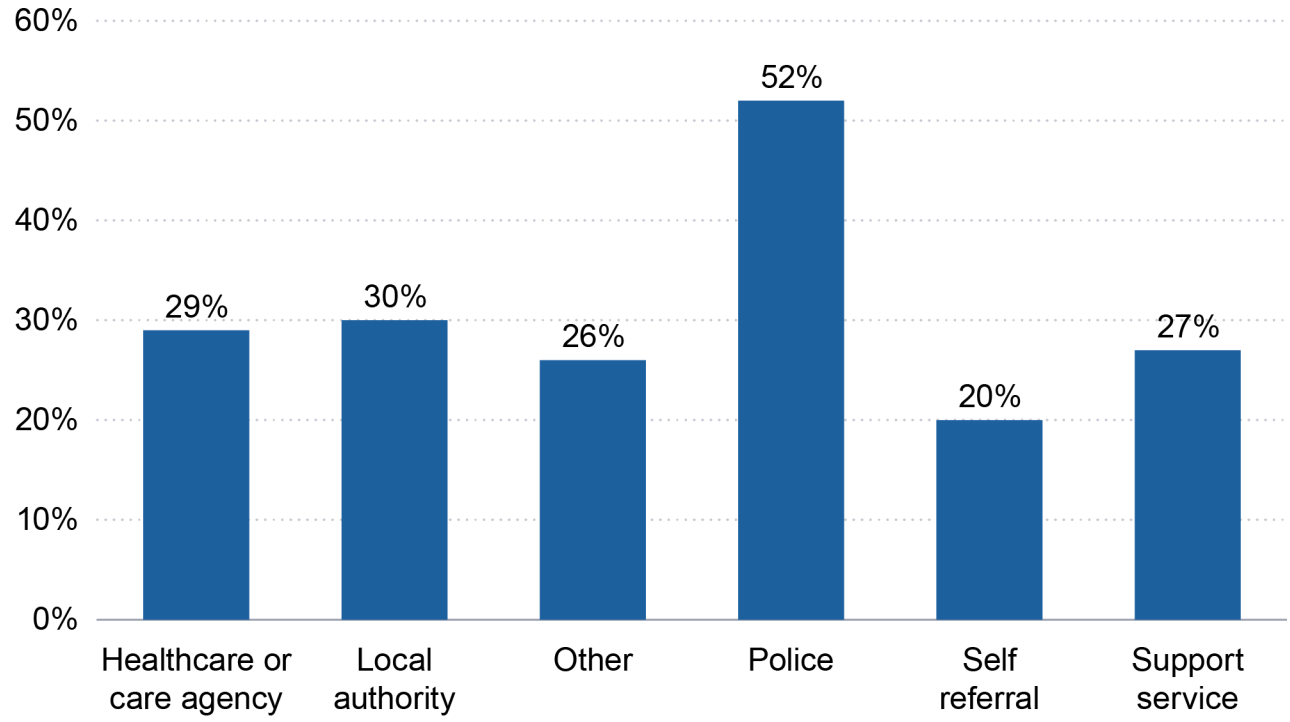


Base = 5,851

Figure 5.13 covers all closed cases in the dataset, with start dates between June 2001 and May 2023.

As previously mentioned, the referral forms include minimal information to avoid the need to share personal data before trust with an organisation is established or time-consuming forms acting as a barrier to access. As a result, little is known about those who drop out before an assessment which makes analysis of this cohort challenging. However, information that shows their referral source and primary incident is available. The below figure 5.14 shows that police referrals have the highest attrition rate at this stage, with one in two cases that were referred by the police dropping out before completing an assessment (52%).

Figure 5.14: Proportion of all closed cases dropping out at each between stage 1 and 2 – by referral source



Base = 5,851

Figure 5.14 covers all closed cases in the dataset, with start dates between June 2001 and May 2023.

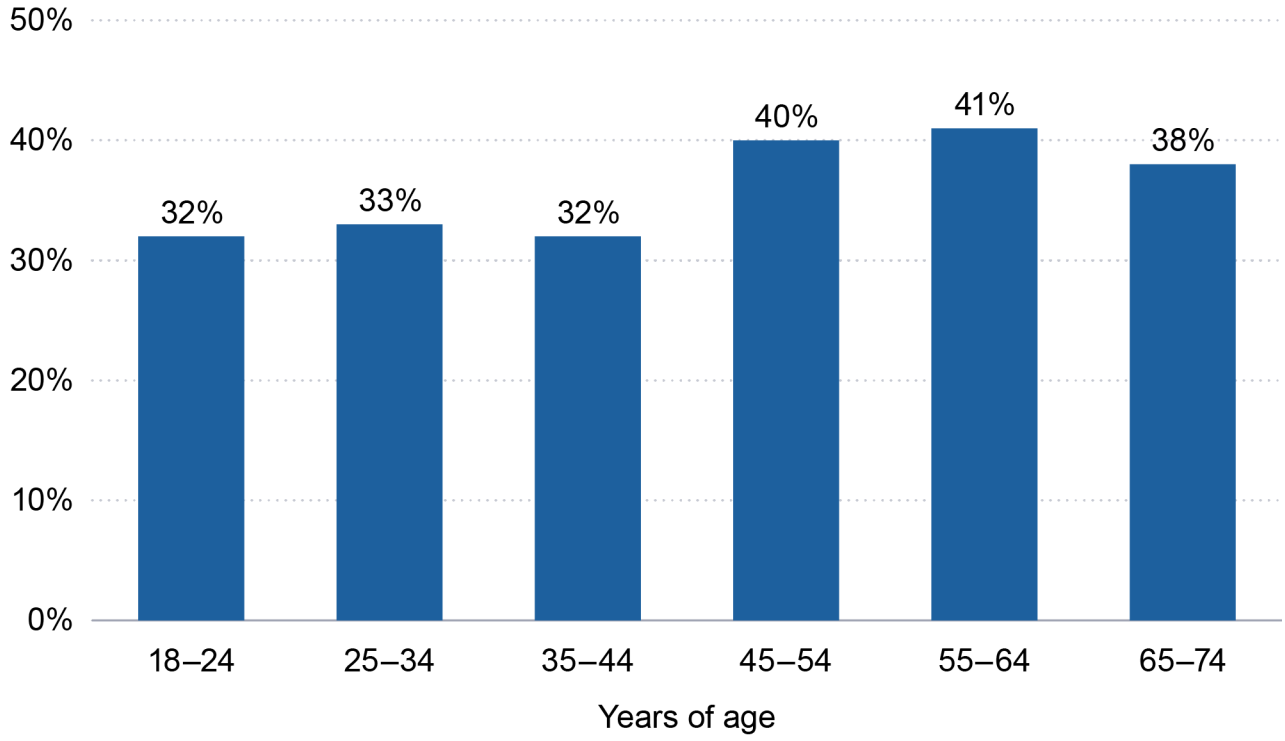
It could be suggested that the initial drop-out before assessment stage is linked to the police pathway model discussed earlier in this report. Whilst we cannot draw direct conclusions, a logical assumption could be made when considering that of those referred by the police with a primary incident of rape, less than half go on to complete an assessment (45%). This compares 61% of CSA cases and 51% of other sexual offence cases.

Whilst the police referral pathway may indicate higher attrition, it is a positive route in for those who wish to engage with support early. However, this route could explain why so many cases that are referred within 24 hours of the incident being reported to the police disengage. For those with a primary incident of rape who self-referred, the majority waited at least 6 months before seeking support (83%), and over half waited more than 2 years (64%). Many victim-survivors, although they have consented, may not fully be ready to engage with the service so soon after the incident. Therefore, rather than this initial drop

out being viewed as failure of the support service, it could be seen as an effective model of ensuring that many victims of crime are directed to early intervention and support should they wish to access it. Where further research could be beneficial is to understand why victim-survivors wait to seek support, when is the best point to direct them to support and what are the benefits of encouraging them to seek support sooner.

In figure 5.15, fewer planned closures are seen amongst younger age groups within the data. Only 1 in 3 of those aged 18 – 44 complete their programme of support in a planned way. As the age of victim-survivor increases, the total percentage of planned closures also increases. This suggests that younger people may be less likely to engage with the service and are at higher risk of dropping out compared to older victim-survivors.

Figure 5.15: Percentage of closed cases with a planned closure – by age



Base = 5,767

Figure 5.15 covers all closed cases in the dataset, with start dates between June 2001 and May 2023 where age was supplied.

However, the sample size of older victim-survivors within the dataset is considerably smaller than younger victim-survivors. Wider literature highlights that older victim-survivors

may face barriers that deter them from accessing support services such as ageist beliefs and attitudes based on rape myths linked to sexual desire and perceptions that older people are sexually undesirable (Bows, 2018). Furthermore, two participants in a study conducted by Scriver, Mears & Wallace (2013) stated that they were unaware support services were available to them. This was due to the belief that services did not deal with non-recent events and that services were only available to those who were younger and had experienced stranger rape. Further research on a larger scale could be carried out to explore the potential relationship between age and support service engagement. In addition, work to develop an understanding of the barriers experienced by older victim-survivors could support service work design to assist in improving engagement amongst this cohort.

When looking at accommodation status, planned closure rates are highest amongst victim-survivors who report that they have a stable living situation. This illustrates the need for a joined-up strategy to aid victims, not only across the CJS but also with other organisations, such as local authorities. Almost half of cases where the victim-survivor owns or rents a home (44%) and 41% of those living with family and friends have a planned closure. This is compared to those with other and temporary accommodation (28%) and those who are homeless including sofa surfing (25%).

Returners

Within the data there are 4,885 new cases and 1,572 returning cases. Returners have been identified using a data field which explicitly states whether a case is new or returning. A new case will be opened for an individual if they return to the service to access further support after their previous case is closed. A victim-survivor can return to the service for many reasons. Examples of this include a new incident, the anniversary of an incident, or because they previously disengaged. They can return to the service regardless of whether they completed their previous programme of support in a planned way, and for both existing and new incidents. Whilst it is possible to link new and returning cases for individuals within the data, the snapshot of data shared from a specific time period means that not all original cases for returning cases are present in the data.

Of the 4,439 new closed cases in the dataset, 34% had a planned closure (1,528). Of those who had a planned closure, 10% returned to the service once, (159), 1% returned twice, (18) and only 2 returned to the service three times. The majority of those who finished their programme of support in a planned way only have one case in the dataset meaning that they did not return to the service in the period that the data covers (88%).

For the remaining 66% (2911) of closed cases that did not complete their first case in a planned way, 13% returned to the service once (379), 3% returned twice (91), 1% returned three times (24) and less than 1% (19) returned more than three times. For those that returned to the service once, 36% (135) had a planned closure on their second case. For those that returned to the service twice, 54% (49) had a subsequent planned closure. Again, most cases that did not complete their service in a planned way did not return to the service in the period that the data covers (82%).

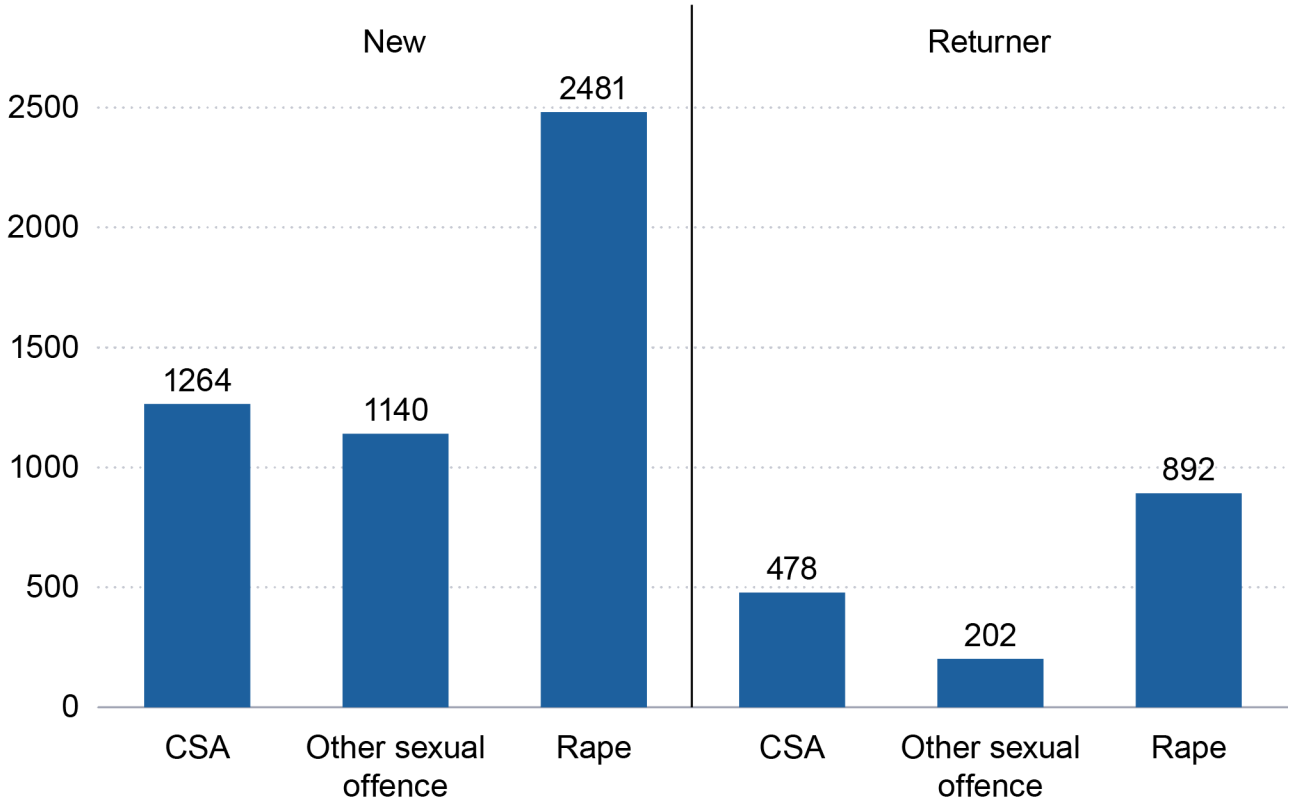
It should be considered that as victim-survivors can return at any time, individuals may return in the future which would impact the above figures. However, the current data suggests that victim-survivors who do not complete their first case in a planned way are more likely to return to the service.

The data also suggests that younger victims are most likely to return to the service. When looking at the average number of cases in the dataset for each age group, 18 – 24-year-olds had 1.25 cases per individual, closely followed by 25 – 24-year-olds who had 1.23 cases. This compares to 1.19 cases for 35 – 44-year-olds, 1.21 for 45 – 54-year-olds, 1.17 for 55 – 64-year-olds, 1.15 for 65 – 74-year-olds, and 1 case for 75 years and over.[45] This aligns with the findings that suggest younger individuals in the data are least likely to end their case in a planned way.

When looking at returning cases by crime type, those with a primary incident of rape account for over half of all returners (57%). Although returning victim-survivors can return for a new incident or the same incident as before, the majority present with the same crime type as their previous case (90%).

[45] The age used is the victim-survivors age at the start of their first case in the dataset.

Figure 5.16: Count of new and returning cases



Base = 6,457

Figure 5.16 covers all cases in the dataset, with start dates between June 2001 and May 2023.

Victim attrition from the CJS

The data includes information that provides insight into why victim-survivors disengaged from the CJS process for incidents that have been reported to the police. It is important to consider that if an individual comes to the service with a primary incident of rape but has experienced sexual violence in the past, both incidents are recorded. This data is based on all incidents (not primary incident) meaning that withdrawal reasons may be for historic incidents. Victim-survivors can select multiple reasons for withdrawal. This includes 577 incidents, relating to 523 unique individuals. As incidents are linked to individuals, victim-survivors who return to the service and have multiple cases may have duplicate incidents within the data. Therefore, individuals rather than cases or incidents have been analysed.

The total number of individuals that had a reason for withdrawal from the CJS recorded within the data is low (11%). However, it could be suggested that rather than missing

values this could be the result of low withdrawal rates from the CJS for victim-survivors who engage with SWERCC.

The most common reason given by victim-survivors was belief that the process will be too distressing (36%). This was followed by the need to move on (19%), fear of impact on mental health (16%), fear of impact on family (12%), and fear of further violence (11%). A peak in disclosure of privacy concerns was seen in 2019, with 32 victim-survivors stating this as a concern.

This data provides some level of insight into potential reasons for attrition from the CJS; however, it is still limited without wider context relating to their experience. There are potential benefits of linking this data to other organisations such as local police, CPS, and courts data. This would allow further in-depth analysis exploring factors that may impact attrition, such as compliance with the Victims' Code. For example, was the victim offered access to support services at police stage, was the victim offered information about special measures,[46] and how did this impact engagement.

In the Victims' Commissioner (2020) survey, it was found that almost half of those who reported to the police were not told about available measures in court such as a screen to shield them from the defendant (44%). Whilst the small sample size should be considered, overall, the findings from that survey highlight that victims of sexual offences have poor experiences and low confidence in the CJS process. Whilst such research exists that uncovers issues within the system, the lack of data quality and therefore lack of meaningful linked data means that it is challenging to understand the prevalence of such issues on a larger scale. Furthermore, poor quality victims' data means that performance and compliance with the Victims' Code cannot be measured across organisations. This further highlights the importance of ensuring that quality victim data is collected.

[46] Special measures are measures which have been put in place to help vulnerable and intimidated witnesses give their best possible evidence in court.

6. Conclusion

To improve outcomes for victims of crime, a holistic understanding of victims' needs and their experiences of the CJS and support services is required. This is essential to ensuring policymakers are best placed to make data-driven and evidence-based decisions to develop effective policies and interventions. The findings from this research suggest that third sector support services may be key organisations in the victims' data landscape to support this.

As a proof-of-concept feasibility project, the primary aims of this research were:

- to discover what data a specific third sector service holds and to examine the completeness of the data,
- to understand if it is possible to use this data to assess the services that victim-survivors need and identify typical support packages offered,
- to examine a victim-survivor's journey through a support service and,
- to understand if it is possible to use this data to understand victim-survivor disengagement from the support service.

Secondary aims were to understand how this data fits into the wider victim data landscape and understand the benefits of linking this data to other organisations. This research is the first step to realising the potential benefits, insights, and context that data collected in a third sector support service environment can provide to the wider data landscape.

The SWERCC dataset includes high quality, complete data that is primarily victim-level. This level of data is often not routinely collected by the government and CJS organisations. For example, whilst police data focuses on the crime and investigation, and probation data focuses on the offender, SWERCC data focuses on the victim-survivor. As the aim of the service is to support victim-survivors to cope and build resilience, the data is collected with the intention of developing an understanding of their circumstances, needs, and what support is required. Data is also collected that provides insight into engagement with the service.

From the data, the key findings are:

- For victim-survivors who completed a before and after questionnaire, it is indicated that engagement with SWERCC has a positive impact on a victim-survivor's ability to cope and build resilience and is therefore working as intended for those who engage with the service.[47]
- As expected from the wider literature, the most common victim-survivor typology for those who are over 18 years of age is females between the age of 18 – 44 with a primary incident of rape (42%).
- Police forces are the most common referral stream into the service (33%), almost all of which are from Essex Police. Most referrals are received from non-police sources.[48]
- The most common risks, issues and impacts across all primary incident types suggest that victim-survivors most commonly attend the service with needs relating to mental health and psychological wellbeing.[49]
- Over half of victim-survivors (57%) waited for more than two years before reaching out to seek support and contacting specialist services.
- Victim-survivors who waited more than two years to seek support had a higher prevalence of poor mental health (31%), compared with those who waited less than a week (24%), and those who waited between a week and a month (21%). However, it is unclear if poor mental health was pre-existing (before the incident), or as a result of the incident.
- As expected from the wider literature, the most common type of perpetrator is someone known to the victim-survivor (81%).
- The most common service accessed was therapy (38%). This was followed by the use of the wraparound service (both therapy and advocacy) (20%).
- The largest level of attrition from the service happens between the initial referral and the victim-survivor completing an assessment of needs (34%).

[47] Of victim-survivors who completed a before and after questionnaire, 85% had an improved score. Completing an after-service questionnaire is most common amongst cases that end in a planned closure.

[48] Self-referrals are the second most common referral source (27%). This is followed by healthcare agency (22%), support service (11%), local authority (4%), and other (2%).

[49] The most common risk was at risk of mental health (17%). Post-trauma symptoms were the most common issues (49%) and impact (58%).

- Nearly 50% of all cases disengage before receiving any type of service.
- Disengagement from the service is highest amongst police referrals, with only 26% of cases ending in a planned way. Those who self-refer are least likely to disengage, with 43% ending in a planned way.
- Disengagement from the service is most common amongst 18 – 44-year-olds. Victim-survivors under the age of 44 had a planned closure rate of 32%, compared with 40% for victim-survivors over the age of 44.

In summary, many victim-survivors present to the service with multiple and complex needs, primarily related to poor mental health. Many victim-survivors wait for more than two years before reaching out to seek support from specialised services and a higher prevalence of poor mental health was found within this cohort. The largest level of attrition from the service happens after the initial referral and before completing an assessment of needs, many of whom are referred by the police soon after the incident.

However, whilst the data provides such findings that are beneficial for developing the current evidence base, the quantitative methods used for analysis mean that there are still many unanswered questions. For example:

- Why are victim-survivors waiting more than two years to seek support and how can they be supported to engage with services sooner?
- Why do many of those referred by the police disengage before completing an assessment and is the service engaging with victim-survivors at the right time?
- Is the service meeting their needs and what improvements could be made to the service to encourage engagement?

Qualitative work or potentially analysis of free text case notes (if access could be agreed) could be carried out to complement the findings and further develop insight gathered from this research.

Furthermore, due to the sample of data analysed findings cannot be generalised to all victim support services nationally. It is still not clear if similar trends exist within other support services in England and Wales, and if quality data of a similar nature is collected across other third sector and CJS support services. Further research could be conducted

on a larger scale to explore this and assess the feasibility of data linking. How trends vary by demographics, protected characteristics and crime type could also be explored on a larger scale.

This research however is the first step to realising the potential benefits, insights, and context that data collected in a third sector support service environment can provide to the wider landscape. It also highlights the importance of data standards across organisations, ensuring that key variables such as protected characteristics are defined and counted consistently to enable the identification of commonalities and trends.

Linking support service data to data held by government departments and other organisations such as the police and CPS data could allow a more comprehensive understanding of attrition and victim-survivor needs to be developed. For example, how engagement with support services impacts engagement with the CJS process. It may also provide the opportunity to explore if areas such as victim needs, risks and protected characteristics act as potential barriers or enablers to engagement with the CJS.

Third sector support services could provide the victim lens data to the data landscape that is required to build an evidence base around what works for improving victim engagement with the CJS process and support services. As a result, policymakers could have better quality evidence to support data-driven policy decisions. By better joining up the evidence and data used to run services, the design and delivery of services for victims could be improved, thereby improving outcomes for victims of crime.

This report is not comprehensive of all analysis that can be delivered from this dataset and further publications are expected. This may include projects that involve linking the dataset, alongside further exploration of how different cohorts of victim-survivors within the data engage and interact with third sector support services.

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Key Terms and Abbreviations

Agency	An external organisation that can refer service users, for example, healthcare agencies or other victim support agencies.
BOLD	BOLD (Better Outcomes through Linked Data) is a government data-linking programme which aims to improve the connectedness of government data in England and Wales.
Case	A continuous period of interaction a victim-survivor has with one of the SWERCC centres, where support is offered.
Closed Case	That period of interaction between a victim-survivor and SWERCC has ended.
CJS	Criminal Justice System.
CPS	Crown Prosecution Service. Prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales.
CSA	Child Sexual Abuse.
CSE	Child Sexual Exploitation.
CSEW	Crime Survey for England and Wales.
DPMS	Data Performance Management System. The SWERCC case management system.
IAPT	Improving Access to Psychological Therapy.
Incident	An alleged crime that was committed.
ISVA	Independent Sexual Violence Advisor.
New Case	The first time that individual has received support from SWERCC.
No incident	In primary incident field this is where the person seeking support was not the direct victim of the crime.
OIC	Officer in case. The police officer with overall charge of the case against a person.
Open Case	The support from SWERCC was still ongoing when the data was shared.
Planned Closure	The victim-survivor finished the programme of support and there is an outcome form logged on DPMS for the service provided.
Primary Incident	The reason the victim-survivor sought support. Victim-survivors may have experienced multiple different incidents, but each case has a single primary incident.
RCC	Rape Crisis Centre.

Returning Case	The victim-survivor had a previous case with SWERCC that had been closed. The victim-survivor then begins a subsequent case.
SARC	Sexual Assault Referral Centre.
Service	Support offered by SWERCC. The main two being Therapy and Advocacy.
SWERCC	South and West Essex Rape Crisis Centres. SWERCC consists of two of the three centres in the Synergy Essex partnership: SERICC Rape and Sexual Abuse Specialist Service and Southend-on-Sea Rape Crisis (SOSRC).
Unexpected Closure	The victim-survivor finished the programme of support without completing any expected services.
Victim-survivor	An individual using SWERCC services. May be the victim of a crime or the relative or partner of a victim.

Appendix A
Data Quality

The below table proved the number of blank entries in each of the fields from the main, cases table that was used for analysis.

Variable	NA Count	Na Per Cent
organisationid	0	0%
clientcaseid	0	0%
personid	0	0%
clientid	0	0%
startdate	0	0%
enddate	606	9%
daysincase	0	0%
role	0	0%
newreturner	0	0%
initialstatus	9	0%
initialstatusfrequency	173	3%
currentstatus	0	0%
currentstatusfrequency	4	0%
initialsituation	25	0%
currentsituation	23	0%
timeelapsedbeforesupport	554	9%
conditions	0	0%
location	0	0%
gender	1	0%
dateofbirth	55	1%
currentage	5	0%
initialage	5	0%
ageatdate	6239	97%
ageband	4	0%

Variable	NA Count	Na Per Cent
agebandid	4	0%
agecategory	6	0%
agecategoryid	6	0%
numberofdependants	0	0%
dependantsummary	825	13%
primaryincident	47	1%
incidentsummary	458	7%
primaryperpetrator	619	10%
perpetratorsummary	865	13%
incidentimpact	647	10%
issues	399	6%
risks	636	10%
disabilities	109	2%
benefits	813	13%
ethnicity1	443	7%
ethnicity2	646	10%
ethnicity3	2654	41%
nationality	332	5%
sexuality	490	8%
religion	610	9%
maritalstatus	449	7%
accommodation	556	9%
employmentstatus	515	8%
primarylanguage	349	5%
languagedifficulty	624	10%
immigrationstatus	401	6%
livingwith	476	7%
familyfriendssupport	1458	23%
socioeconomicstatus	1060	16%
country	2	0%
region	40	1%

Variable	NA Count	Na Per Cent
county	39	1%
area	12	0%
town	561	9%
referraltype1	6	0%
referraltype2	6	0%
referraltype3	79	1%
referralsource1	6	0%
referralsource2	6	0%
referralservice1	6	0%
referralservice2	14	0%
referraldate	0	0%
extraction_timestamp	0	0%

Annex 1
Data Share

A full set of governance documentation including Data Protection Impact Assessment (DPIA) and Data Sharing Agreement was written by the BOLD Victims Pathway Pilot in conjunction with colleagues from SWERCC to ensure that all required adherence to GDPR and the Data Protection Act, 2018 was met. This included providing justification for the lawful basis and proportionality of the data share; with the document signed by representatives from both SWERCC and BOLD.

After governance was fully approved, BOLD received data from SWERCC's case management system, DPMS. Prior to this, SWERCC removed any fields that contained personal identifiable information, (PII), as had been outlined in the DPIA, as well as any free-text fields; ensuring individuals could not be identified by BOLD. The tables were then uploaded on to the MOJ Analytical Platform by SWERCC.

Access to this dataset was granted to the three data analysts in the BOLD VP team via the GitHub platform to be analysed in correlation to the stated purposes of the data share.

Annex 2
Reasons for a service ending

Reason	Definition
Did not engage	The client did not respond to contact to enable service to be provided or the client responded but did not attend any planned appointments.
Not brought to service	This should be used in a case when the client is a child or has a learning difficulty and relies on an appropriate adult e.g. parent/social worker to bring them to appointments. If that adult has not brought them to the appointment the closure reason should be not brought to service.
Disengaged	The client attended 1 or more appointments but did not finish the service programme of support in a planned way.
Unplanned closure	Relates directly to a specific reason that the client can no longer attend e.g. the client is taken into hospital, the client is deceased, the client suddenly moves home to a new area without notice.
Planned closure	The client finished the programme of support and there is an outcome form logged on DPMS for the service provided.
Inappropriate referral	The client requires a different kind of service e.g. a domestic abuse service and The client has not been impacted by or experienced sexual violence.
Declined service	Successful contact was made with the person being referred but they decided that they did not want a service from us.
Service Denied	The service has assessed the client who has been referred and deemed the person not suitable to receive our services, e.g. the client is not stable enough to begin therapy.
Dual Status service denied	It has been discovered that the client has previous offences of a sexual nature and the case is being closed.
Referral incomplete	A referral has been made and the referrer has not supplied the required information (e.g. missing contact details), attempts have been made to contact the referrer but with no response. Close the case as referral incomplete.
Referral withdrawn	This only relates to a professional withdrawing the referral (not clients – this should be marked declined service).
Referred on	This should only be used when closing a case because they are being referred to another service e.g. the client moves home and the case is referred to a rape crisis centre in their new area. This should not be used for referring on to internal staff.

Reason	Definition
Engaged W/L	When closing a waiting list case group – if the client moves on to the next stage e.g. receiving service – additional 1, in case groups should be updated to show that the client engaged from the WL to the next stage.
DNE W/L	When closing a waiting list case group – if the client did not move to the next stage e.g. receiving service – additional 1 should be updated to DNE W/L indication that they did not engage further.
Transferred to another worker	The client is allocated to one worker but for some reason needs to be transferred to another worker – you only need to add a new worker – please do not create a new case group as well, as the client remains in the case group that was originally created it is just the worker who has changed.
Transferred to another RC Centre	The case was closed because the client moved area and was transferred to another centre.
Service withdrawn	The services were withdrawn due to a number of reasons e.g. the client was abusive towards staff.

Annex 3
Risks, issues, and incident impacts

Risks	Issues	Incident Impact
At high risk in prostitution	Access issues childcare	Adoption
At high risk of abduction	Access issues transport	Aggression
At high risk of CSA	Accommodation Problems	Agoraphobia
At high risk of CSE	Alcohol problems past	Alcohol misuse
At high risk of deportation	Alcohol problems present	Anger
At high risk of DV	Anxiety	Anger/Aggression
At high risk of female infanticide	Bullying	Anxiety
At high risk of FGM	Care leaver	Bed wetting
At high risk of forced marriage	Caring responsibilities	Behavioural issues
At high risk of HBV	Child sexual abuse	Bereavement/loss
At high risk of mental illness	Complex PTSD	Body problems
At high risk of running away	Current CSA	Bullying
At high risk of self harm	Current DV	Claustrophophia
At high risk of substance misuse	Current SV	Complex PTSD
At high risk of suffering violence	Depression	Compulsions
At high risk of suicide	Diagnosed – Addiction	Confusion
At high risk of SV	Diagnosed – Alcohol-use disorders	Declined service
At risk in prostitution	Diagnosed – Anxiety	Delusions
At risk of abduction	Diagnosed – Attention Deficit Disorder	Depression
At risk of CSA	Diagnosed – Attention Deficit Hyperactivity Disorder	Difficulty forming relationships
At risk of CSE	Diagnosed – Autism	Disengaged
At risk of deportation	Diagnosed – Bi-Polar	Dissociation

Risks	Issues	Incident Impact
At risk of DV	Diagnosed – Body dysmorphic disorder	Drug misuse
At risk of female infanticide	Diagnosed – Brain injury	Eating problems
At risk of HBV	Diagnosed – Dementia	Family relationship breakdown
At risk of mental illness	Diagnosed – Depression	Fear
At risk of running away	Diagnosed – Dissociative Identity Disorder	FGM
At risk of substance misuse	Diagnosed – Drug misuse	Flashbacks
At risk of suffering violence	Diagnosed – Eating disorder	Forced termination of pregnancy
At risk of SV	Diagnosed – Epilepsy	Gender issues
High level need	Diagnosed – Fibromyalgia	Guilt/shame
High risk	Diagnosed – OCD	Gynae disorder
High risk DV perpetrator	Diagnosed – Personality disorder	Hallucinations
High risk MARAC	Diagnosed – Psychosis	Hearing voices
High risk of SV	Diagnosed – PTSD	HIV as result of rape
High risk SV perpetrator	Diagnosed – Schizophrenia	Homelessness
High risk violent perpetrator	Diagnosed – Self-harm	Hyper vigilance
Immediate risk	Difficulty forming relationships	Interruption to education
Low level need	Drug problems past	Interruption to employment
Low risk	Drug problems present	Intimacy issues
Low risk MARAC	Eating disorder	Intrusive thoughts
Medium risk	Financial difficulty	Isolation
Medium risk MARAC	Forced termination of pregnancy	Lack of insight/understanding
Mid level need	Gambling problems past	Loss of memory
No known current risk	Gambling problems present	Loss of work/income
No risks	Harmful Sexual Behaviour	Low mood
Not able to obtain	History of CSA	Low self esteem
Risk of self harm	History of CSE	Mental health

Risks	Issues	Incident Impact
Risk of suicide	History of DV	Mimicking abusive behaviours
	History of SV	Miscarriage as result of abuse
	Hoarding	Mistrust
	Homelessness	Negative self image
	Intimacy issues	Nightmares
	Maternity	Not able to obtain
	Mental health past	Not yet obtained
	Mental health present	Obsessive thoughts
	Miscarriage	OCD
	Missing adult	Overdose
	Missing child	Panic attacks
	Modern slavery	Paranoid personality disorder
	Multiple mental health diagnoses	Parenting problems
	None	Personality problems
	Not able to obtain	Phobias
	Other	Physical injuries
	Paranoid personality disorder	Post trauma symptoms
	Parenting problems	Pregnancy as result of abuse
	Personality problems	Prescription Medication
	Post trauma symptoms	PTSD
	Pregnancy	Relationship breakdown
	Prescription medication	Relationship problems
	Prostitution	Restrictions to movement/activities
	PTSD	School truancy
	Racism	Self blame
	Recent birth	Self harm
	Safeguarding issues	Self-neglect
	Safety issues	Severe & enduring mental health

Risks	Issues	Incident Impact
	Self harm past	Sexual problems
	Self harm present	Sexualised behaviour
	Self-neglect	Sexualised language
	Sex selection	Sexuality issues
	Sexual violence	Sexually Transmitted Infection
	Single parent	Sleep problems
	Sleep problems	Social isolation
	Suicidal attempt past	Stress
	Suicidal thoughts past	Study difficulties
	Suicidal thoughts present	Suicidal thoughts
	Termination of pregnancy	Suicide attempts
	Unknown did not engage	Termination of pregnancy
	Witnessed CSA	Triggers
	Witnessed DV	Work difficulties
	Witnessed SV	NA
	Young Carer	