



**Liverpool
Public Health
Observatory**

Sexual Violence Needs Assessment For Merseyside

**Final Report
August 2011**

Lyn Winters

Observatory Report Series No. 85

PROVIDING INTELLIGENCE FOR THE PUBLIC HEALTH

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Liverpool Public Health Observatory

Liverpool Public Health Observatory was founded in the autumn of 1990 as a research centre providing intelligence for public health for the five primary care trusts (PCTs) on Merseyside: Liverpool, St. Helens and Halton, Knowsley, Sefton and Wirral. It receives its core funding from these PCTs.

The Observatory is situated within the University of Liverpool's Department of Public Health and Policy. It is an independent unit. It is not part of the network of regional public health observatories that were established ten years later, in 2000.

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Abbreviations

ACPO	Association of Chief Police Officers
AF	Attributable Fraction
BCS	British Crime Survey
BME	Black and Minority Ethnic
CAMHS	Child and Adolescent Mental Health Service
CRB	Criminal Records Bureau
CSP	Community Safety Partnership
CSA	Child Sexual Abuse
FICU	Family Investigation Crime Unit
FMEs	Forensic Medical Examiners
FSU	Family Support Unit
GUM	Genitourinary medicine
HIV	Human Immunodeficiency Virus
ISVA	Independent Sexual Violence Advisor
IDSVA	Independent Domestic Sexual Violence Advisory Service
IDVA	Independent Domestic Violence Advisor
IMD	Index of Multiple Deprivation
LAPE	Local Alcohol Profiles for England
LPHO	Liverpool Public Health Observatory
MARAC	Multi Agency Risk Assessment Conference
NEW-ADAM	New English and Welsh Arrestee Drug Abuse Monitoring System
ONS	Office for National Statistics
PCT	Primary Care Trust
PEP	Post Exposure Prophylaxis
PEPSE	Post Exposure Prophylaxis following sexual exposure to HIV
RASA	Rape and Sexual Abuse Centre
RASASC	Rape and Sexual Abuse Support Centre
SARC	Sexual Assault Referral Centre
SPM	SAFE Place Merseyside
SOAs	Lower Super Output Areas
STIs	Sexually Transmitted Infections
VVAT	Vulnerable Victims Advocacy Team

Contents

Acknowledgements	3
Abbreviations	5
Summary	11
Discussion	18
Recommendations.....	20
Background to the project	22
Objectives	22
Methods	23
Communication plan.....	23
Interested Parties.....	23
Method of Communication.....	23
Population Profile for Merseyside.....	24
Age/sex.....	24
Ethnicity	24
Deprivation	25
Definition of sexual violence and child sexual abuse	27
Sexual Violence Legislation	27
The British Crime Survey.....	28
Nationally Recorded Crime from Home Office Statistics for England and Wales .	31
Factors associated with sexual violence	32
Young age	32
Having previously been sexually assaulted when young	32
Poverty	33
Being married or cohabiting.....	33
Social Norms of male entitlement.....	33
Consuming alcohol and drugs	34
Involvement in sex work	35
Mental illness, learning and Physical Disability.....	36
Costs of sexual violence.....	36
National Standards for SARCS	37

Sexual Assault Services in Merseyside.....	38
SAFE Place Merseyside.....	38
Follow-on services.....	41
Independent Sexual Violence Advisor (ISVA).....	41
Rape and Sexual Abuse Centre (RASA).....	41
Rape and Sexual Abuse Support Centre (RASASC).....	41
Vulnerable Victims Advocacy Team (VVAT) – Bootle, Sefton.....	42
ISVA specialist provision for sex-workers.....	43
Services for children (under 16 years).....	44
Joint Police/CPS Unity Team.....	44
Data from SAFE Place Merseyside.....	46
Self-Referral Telephone enquiries to SPM:.....	52
September 2009 – March 2011.....	52
Background.....	52
Performance Activity.....	52
Benefits of offering a Self-referral service.....	56
Financial Implications of offering a self referral service.....	57
Problems with data from SAFE Place Merseyside.....	57
Activity Data from Alder Hey Rainbow Centre.....	58
RASA Activity data – year ending 2010.....	60
Problems with the data from RASA.....	61
Data from Rape and Sexual Abuse Support Centre (RASASC).....	62
Problems with RASASC data.....	65
Police Reported offences on Merseyside.....	65
Problems with police data.....	71
Vulnerable Victims Advocacy Team (VVAT).....	72
Multi-Agency Risk Assessment Conference (MARAC) Data.....	72
Armistead Centre.....	73
Other Health Service Data.....	73
Some key issues reported to the researcher.....	74
References:.....	76

List of Tables

Table 1: Population of Merseyside 13 and over by gender and age-group	24
Table 2: Ethnic composition of Merseyside population 13 +	24
Table 3: Composition of the minority ethnic population aged 13+	25
Table 4: Merseyside LA District indicators of Deprivation 2007	25
Table 5: Prevalence of sexual offences among 16-59 year olds in the past year based on the British Crime Survey 2009/10	29
Table 6: Estimated numbers aged 16-59 by Local Authority on Merseyside that could have been a victim of sexual assault (including attempts) each year	30
Table 7: Prevalence of victims once or more among 16-59 year olds based on the British Crime Survey 2009-10	30
Table 8: Risk factors associated with sexual violence from research.....	32
Table 9: Sexual crimes attributable to offender alcohol intake in Merseyside 2009/10	35
Table 10: Sexual crimes attributable to alcohol by Local Authority	35
Table 11: Key elements of a SARC.....	37
Table 12: Composition of the minority ethnic clients of SPM aged 13 and over 2008-2010 number (%)	48
Table 13: Ethnicity of Referred Clients	48
Table 14: Forensic Examination by sexual offence 2008-2010	50
Table 15: Medication provided to SPM clients during 2008-2010 – number (%).....	51
Table 16: Referral to other services 2008-2010 – number (%).....	51
Table 17: Total telephone calls received by SPM: 22 September 2009 – 31 March 2011	53
Table 18: Self Referral Calls to SPM: 1 st April 2011 – 30 June 2011	56
Table 19: Wards with the highest recorded sexual offences on Merseyside during 2008-2010 by deprivation.....	67
Table 20: Wards with the lowest recorded sexual offences on Merseyside during 2008-2010 by deprivation.....	68
Table 21: Composition of the minority ethnic victims of sexual offences aged 13 and over 2008-2010 number (%)	68
Table 22: St Helens MARAC from Jan 2008 – Dec 2010.....	72

Table of Figures

Figure 1: Adult Sexual Assault Care Pathway.....	40
Figure 2: Intelligence Flow Merseyside SARC	45
Figure 3: Gender and Age of victims attending SAFE Place Merseyside, 2008-2010	46
Figure 4: Seasonal variation: attendances at SPM and month of assault (March 2009 – February 2010).....	46
Figure 5: Attendance and day of assault recorded at SAFE Place Merseyside	47
Figure 6: Percentage of SAFE Place Merseyside Clients resident in each PCT 2008- 2010	47
Figure 7: Number of SAFE Place Merseyside Clients with a disability 2008-2010..	48
Figure 8: Source of Referrals to SPM (%) 2008-2010	49
Figure 9: Type of offence reported by clients attending SPM -2008-2010.....	49
Figure 10: Knowledge of perpetrator, SPM clients – 2008-2010	50
Figure 11: Referral to ISVA services SPM clients 2008-2010	51
Figure 12: SPM self-referral telephone calls from all areas.....	54
Figure 13: SPM self-referral telephone calls from St Helens.....	54
Figure 14: SPM self-referral telephone calls from Knowsley	55
Figure 15: SPM self-referral telephone calls from Liverpool.....	55
Figure 16: SPM self-referral telephone calls from Sefton.....	55
Figure 17: SPM self-referral telephone calls from Wirral.....	56
Figure 18: Gender and Age of victims attending the Rainbow Centre, 2008-2010..	58
Figure 19: Seasonal variation: attendances at Alder Hey (2008-2010)	58
Figure 20: Source of referral to the Rainbow Centre (%) 2008-2010	59
Figure 21: Percentage of Rainbow Centre Clients resident in each PCT (2008-2010)	59
Figure 22: Gender of RASA Clients during 2010.....	60
Figure 23: Presenting Issues of RASA clients, during 2010	61
Figure 24: Gender and Age of clients attending RASASC, 2009-2010	62
Figure 25: Percentage of RASASC clients resident in each LA 2009-2010	62
Figure 26: Presenting Incidents of RASASC Clients 2009-2010	63
Figure 27: Source of Referral to RASASC (%) 2009-10.....	63
Figure 28: RASASC clients' relationship to perpetrator, 2009-10.....	64
Figure 29: Whether the RASASC incidents were reported to the police, 2009-10 ...	64
Figure 30: Gender and age of victims from Merseyside police data, 2008-2010.....	65
Figure 31: Seasonal variation in offences by earliest date of crime on police data (Jan 2008 – December 2010).....	66
Figure 32: Day of assault recorded by police (2008-2010).....	66
Figure 33: Time of sexual offence from police data (2008-2010)	66

Figure 34: Percentage of police reported offences in each Local Authority 2008-2010	67
Figure 35: Number of reported sexual offences to the police – 2008-2010	69
Figure 36: Sexual offences that are classed as domestic violence on police data 2008-2010	69
Figure 37: Whether victim knew perpetrator from police data	70
Figure 38: Alcohol influenced sexual offences from police data	70
Figure 39: Drug influenced sexual offences from police data	70

Summary

This sexual violence needs assessment for Merseyside was undertaken by Liverpool Public Health Observatory. It aims to ensure that provision meets actual need and to reduce organisational barriers. The needs assessment reviews current activity in sexual violence services in Merseyside utilising data from Police, third sector and health and social care agencies for those aged 13 years and above. Intelligence on need is supplemented from the British Crime Survey. The review also summarises the factors associated with sexual violence. The findings from this review will inform the strategic review of the commissioning arrangements for the provision of the Sexual Assault Referral Centre (SARC) services for the population of Merseyside. It will ensure that all people will receive optimum high quality care when they need it, not being dependent on their age or area of residence within Merseyside.

Population Profile for Merseyside

Age-sex profile

From the Office for National Statistics (ONS) population estimates for 2009 there were 1,155,322 people of 13 years and over on Merseyside, which consists of 552,075 (47.8%) males and 603,247 (52.2%) females.

Ethnicity

On Merseyside only 4.4% of the population 13 years and over are from black minority ethnic (BME) groups. The largest percentage of people living in BME groups is resident in Liverpool (8.3%) whilst less than 3% of the population in other Merseyside local authorities are from BME groups. The largest proportion of the minority ethnic population aged 13 plus on Merseyside is made up of Asians closely followed by Chinese or other ethnic group.

Deprivation

Liverpool continues to be the most deprived local authority in England, with nearly 56% of Liverpool's residents living in an area that is ranked within the most deprived 10% within England and 68% living in the most deprived 20% in the country. Knowsley is ranked the fifth most deprived in the country where 46% of the population live in communities classed as being within the 10% most deprived in England in relation to overall deprivation. St Helens has 27 Lower Super Output Areas (SOAs) which fall within the most deprived 10% nationally and 43 SOAs in the most deprived 20%. Wirral has nearly a third of SOAs which fall within the 20% most deprived nationally, however there are sharp contrasts with the most severe levels of deprivation predominantly in the docklands areas. Sefton is the least deprived of the Merseyside local authorities, with just over a quarter of its SOAs falling within the 20% most deprived nationally. However, it still has concentrated areas of extreme deprivation coinciding with the most densely populated, urban centres.

British Crime Survey (BCS)

The BCS surveys 16 to 59 year olds about their experiences of sexual violence. According to the 2009/10 BCS, 0.2% of respondents declared that they had experienced a serious sexual assault in the past year. This equates to 1,590 individuals in the 16 to 59 age bracket across Merseyside. The same percentage of respondents reported that they had been raped in the previous year, but whereas serious sexual assault or attempted serious sexual assault was experienced by both genders, the survey only detected female survivors of rape. The data for men as compared to women shows only 0.5% of men experienced some form of actual or attempted sexual assault in the previous year as compared with 2.3% of women. On Merseyside this equates to 1,948 males and 9,327 females. The estimated number of males and females experiencing a serious sexual assault (including attempts) per year on Merseyside is 390 and 1,622 respectively.

According to the BCS 10.9% of the population aged 16 to 59 has been a victim of some form of sexual assault or attempted sexual assault as adults. Applied to this population on Merseyside means 86,658 individuals have a history of sexual assault as an adult.

Nationally recorded crime from Home Office Statistics for England and Wales

On Merseyside during 2009/10 there were 923 recorded sexual offences representing 0.9% of all reported offences (107,730) within the region and a 13% increase in sexual offences from 2008/9. In fact sexual offences are the only type of offence on Merseyside that has shown an increase in police recording from 2008/9. There was a decrease from 4 to 3 sexual offences on Merseyside involving knives or sharp objects from 2008/9 to 2009/10.

Factors associated with sexual violence

There are two types of risk factors: those that increase vulnerability for the individual and factors increasing the risk of committing sexual violence. Some of these factors can be linked to both the perpetration of sexual violence and the risk of being a victim for instance: poverty, a history of child sexual abuse, alcohol and drug consumption. Predominately, women are victims. Also being young, married or cohabitating, involvement in sex work, having a mental illness or a learning or physical disability are all factors associated with being a victim. A social environment that is deeply entrenched in a community belief in male superiority and male entitlement to sex will greatly affect the likelihood of sexual violence taking place.

Activity data from sexual violence services on Merseyside

Each provider was asked for data for the years January-December 2008-2010, but this was not available in all cases on computer software therefore the years do vary for each service.

SAFE Place Merseyside (SPM)

SPM is a Sexual Assault Referral Centre (SARC) for men and women aged 16 and over. All of the key elements of a SARC as set out in the revised National Service Guide have been met by SPM.

SPM received its first three clients on Friday 26th September 2008 and first self-referrals from September 2009, which explains the low numbers in the first year. From September 2008 until the end of December 2010, 531 clients had been seen of which 504 or 95% were female. The majority of attendances (67.8%) came from people aged 16-30. After that age the numbers decline with only 8 attendances from females over 50, including one adult over 60. There was an average of 19 attendances per month.

Most attendances and assault days fall at the weekend. This shows a possible link with the night-time economy. Most clients referred to SPM are resident in Liverpool (214) or the Wirral (116), although this only represents 0.06% and 0.04% of the population 13+ resident in these respective Local Authorities. Only 72 come from Sefton, 48 from Knowsley and 43 from St. Helens.

Data on ethnicity and Primary Care Trust (PCT) of residence was available for 99.1% (526) of clients. Of the 25 clients recorded as Black and Minority Ethnic (BME) attending SPM between end of September 2008 and 2010, almost all (19) were from Liverpool. There were 2 from Sefton and 3 from the Wirral. The ethnicity of referred clients to SPM resident in Liverpool PCT are not significantly different to their proportion in the Liverpool population.

SPM clients are routinely asked if they have a disability. Out of 531 clients giving an answer to this question 20.5% said they had a disability and 422 (79.5%) declared they had none. Of those answering that they had a disability, the highest proportion 48 (44%) had a mental health condition, although this only represented 9% of the whole population.

Only 2 clients were reported as having no understanding of English and 4 had some difficulty. SPM can provide interpreting services for clients with no English and they can also accommodate clients who are deaf. Only 4 clients reported being bisexual and 3 homosexual. However, there were 422 cases where sexual orientation was not disclosed.

The majority of referrals to SPM were known to the police. Merseyside police made the most referrals (462, 87%). Nine self referrals and 6 referrals from the Health Service were later referred to the police making a total of 477 that were known to the police.

Nearly three-quarters of offences reported by SPM clients were for rape. For 13.4% of clients it was suspected that a substance assisted a sexual assault. Eighty-five percent of SPM clients had a forensic examination with police involvement, therefore going through the crown prosecution service (CPS). Statistically significantly more

victims of sexual assault by penetration had a forensic examination when compared to other clients. Of clients having a forensic examination, only 2 did not want to press charges but were happy for the police to use evidence from the forensic examination and 22 wanted no police involvement. A further 54 clients had no forensic examination. Two sexual offences were related to trafficking, 15 were related to sex work and 1 was related to both.

In 57.6% of cases the perpetrator was known to the victim and in 41.2% of cases they were reported as being a stranger. In 15.6% of cases the perpetrator was a partner or ex-partner. In 11 cases the sexual offence took place in the home shared by the victim and the offender and in 127 cases (23.9%) it was the victim's own home.

Supplying Post Exposure Prophylaxis for the prevention of HIV and Hepatitis B can reduce the risk of transmission of HIV or Hepatitis B. In over half of cases, prophylaxis was not required for Hepatitis B or against HIV infection. However, when they were, in most cases they were offered at SPM. Just over a half of clients did not require emergency contraception and nearly 40% received it at SPM with only 2.3% being referred.

Referrals were made for nearly two-thirds of clients for follow-up sexual health services. Nearly a third of clients were referred for advocacy or other non-therapeutic support and only 6 were referred to paediatric services. Only 75 clients refused the support of an Independent Sexual Violence Advisor (ISVA). Two thirds of cases were referred to either the Rape and Sexual Abuse Centre (RASA) or Rape and Sexual Abuse Support Centre (RASASC) for ISVA support. Sefton received 13% of referrals. Thirteen clients (2.5%) were receiving ISVA support from Armistead Street and 13 from out-of-the-region where their home PCT was situated.

The number of self-referral calls received between 22 September 2009 and 31 March 2011 totals 212. As anticipated, the number of self-referral calls was small at first: in the seven months between September 2009 and March 2010, 50 calls were received. However, numbers have subsequently grown; between 1 April 2010 and 31 March 2011, 162 calls have been received. Recent awareness-raising activity has resulted in a dramatic surge in self-referral calls. In particular, it is notable that the SPM website was launched on 28 February 2011. February had already seen more self-referral calls than any previous month - 17 calls compared with a monthly average of 9.6 for the previous months of 2010-11. During March 2011, 49 self-referral calls were received by SPM staff, an increase of more than 500% on the previous average. Indeed, over 23% of the 212 calls were received during March 2011, following the launch of the dedicated website. The numbers are still significantly higher than they have been during April –June 2011 and have resulted in some excellent outcomes as in medical examinations, reporting to the police, completion of anonymous intelligence, referral to GUM Clinics and signposting to counselling.

Rape and Sexual Abuse Centre (RASA)

RASA is an independent voluntary organisation and registered charity that offers free and confidential counselling, advocacy and support to survivors of Sexual Violence

on Merseyside in Wirral, Liverpool, Sefton, and Knowsley. During 2010 they had 995 clients of which nearly 90% were female. Nearly 53% of clients were from Liverpool, of which 30% were receiving ISVA support. Most clients presented with more than one issue. Nearly 45% of clients presented with adult rape followed by nearly 29% reporting child sexual abuse.

Rape and Sexual Abuse Support Centre (RASASC)

RASASC (Cheshire & Merseyside) is a registered charity that started in 1995 and is committed to supporting people who have been affected by rape or sexual abuse based in St Helens and Newton le Willows. It has only been receiving clients from Knowsley and the Wirral for about one year. RASASC aims to provide crucial specialist support, independent advocacy, counselling and information free of charge and in confidence in a safe and non-threatening environment for anyone accessing the service.

The age-range of RASASC's Merseyside clients during a two year period (2009-2010) range from 13-72. The number of clients seen peaks for the 21-30 age-group, although over a third of male clients were between 31-40. Eighty-eight per cent were female. RASASC saw an average of 17 new clients per month from Merseyside.

Two-thirds of RASASC clients were from St Helens during 2009-2010. They only received a contract to receive clients from the Wirral since 23 February 2010. Furthermore, RASASC only received clients from South Liverpool from 8th April 2009–25th November 2010 as the contract for the whole of Liverpool then passed to RASA. Ethnicity was only available for 55.1% of RASASC clients. Of these 97.6% were white. Of 176 clients, where employment status was known, nearly 45% were unemployed.

Rape consisted of nearly a half of all presenting cases to RASASC during 2009-2010, with nearly a third being for child sexual abuse (CSA). In over two-thirds of cases the perpetrator was known to the victim and nearly 44% of incidents took place in either the victim's or family home. Eight cases (2%) were reported to be alcohol assisted and 4 cases (1%) were known to be drug assisted. Over three-quarters of cases were reported to the police.

Unfortunately, the majority of 240 (63.8%) of referrals to RASASC is not specified during 2009-2010 as it was not a requirement at that time to record source of referral. However, RASASC have confirmed that the majority of their referrals are self referrals.

Vulnerable Victims Advocacy Team (VVAT)

Sefton provides an Independent Domestic Sexual Violence Advisory (IDSVA) service via VVAT, giving advocacy and support to very high risk victims of domestic violence, sexual violence and hate crime. They are not a counselling service but do refer to other agencies such as RASA. Unfortunately, Sefton could not provide data from VVAT or from the Multi Agency Risk Assessment Conference (MARAC) as information on sexual violence is not recorded electronically at the moment.

ISVA specialist provision for sex workers

The ISVA operates from **Armistead Street**, an outreach and support service for sex workers across Liverpool, located within the Armistead Centre, Liverpool Community Health Care. The IVSA works in partnership with a number of agencies i.e. health, drugs, housing, police and the voluntary sector. She also co-ordinates the Armistead Street "Ugly Mugs" scheme that enables sex workers to report crimes committed against them to the project. The project can then alert other sex workers to potential attackers. Ugly Mugs is also another means of encouraging sex workers to report crimes to the police. Unfortunately data on sexual violence is only recorded on case files. Therefore, they were unable to provide information at the time requests were made. Administrative support is required by the service. However it was reported that most Armistead Street clients have exited sex work and any other offending.

Services for children (under 16 years)

All children aged 16 or under in the community for whom there are concerns of a serious/specialist safeguarding nature where sexual abuse is suspected are referred directly to the Rainbow Centre at Alder Hey (children's sexual assault referral centre, or SARC).

During 2008-2010 there were 99 clients of which 97% were female between the ages of 13-17. From the age of 16 the majority of clients are seen at SAFE Place Merseyside. Most children under 16 are seen at the Rainbow Centre. Within this 13-17 age-group, in 2008 the Rainbow Centre saw 38 clients, 28 clients were seen in 2009 and in 2010 33 clients. Over these 3 years they saw an average of 3 clients per month aged 13-17.

Most attendances were seen during the winter and spring months during 2008-2010 for this age-group. Family Support Unit (FSU) now known as FICU Family Investigation crime Unit is the police unit which deals with family safeguarding issues in hours. Out of hours the cases are referred by the police. Nearly 93% of clients are referred from the police or FSU, with the majority being referred by the police out of hours.

Most clients, over half, were from Liverpool. No clients were received from the Wirral at this time. Until April 2011 the Rainbow Centre at Alder Hey was not commissioned to provide care for children from Wirral who have experienced sexual assault.

Ethnicity was available for 81 Rainbow Centre clients (81.8%). Of these clients 79 (97.5%) were white British and 2 (2.5%) were BMI: 1 Asian from Liverpool and 1 black British from Stockport.

Joint Police/CPS Unity Team

Merseyside Police have a dedicated Investigative Unit called the 'Unity Team' who will help victims of serious sexual violence.

From January 2008 until the end of December 2010 1,629 sexual offences were reported to the police. This equates to 543 per year or 45 per month reported from victims who were 13 and over at the time of the offence. Over half (52.5%) of

offences occurred during the spring and summer months. Nearly 94% were from female victims. The most recorded offences came from victims in the 16-20 age group totalling 455 making 28% of recorded offences. After this peak the reported offences reduce for each subsequent age-group.

Most offences occurred at the weekend and between the hours 9pm and 5am. This shows a possible link with the night-time economy. Furthermore, 17.2% of reported sexual offences are related to alcohol intake, by the perpetrator or victim. Of these victims nearly 58% were between the ages 16-30. There were 93 (5.7%) sexual offences that were recorded as having occurred on licensed premises. Only 54 sexual offences were related to drug intake by either the victim or offender.

Half of all reported sexual offences in Merseyside are within Liverpool, with a fifth from Wirral. Knowsley has the least reported sexual offences, followed by St. Helens and Sefton.

From the Index of multiple deprivation (IMD) ward scores for 2010 it shows that 10 out of 12 (83.3%) of wards where the highest numbers of sexual offences took place are amongst the most deprived areas. These include Bidston, Birkenhead and Tranmere which are situated in the most deprived dockland areas on the Wirral. There is also a connection with the night-time economy as Central Liverpool, Dukes, (the two relatively less deprived wards) Birkenhead, Linacre and St Helens Town Centre are areas that cater for the night-time economy with nightclubs and public houses. Riverside also includes the southern part of the Liverpool City Centre.

Out of 16 wards, with a very low number of sexual offences recorded, 11 or nearly 69% were amongst the least deprived within Merseyside.

Data on ethnicity was available for 84.2% (1371) of victims reporting a sexual offence. Of the 61 victims recorded as Black and Minority Ethnic (BME) representing 4.4% of all victims between 2008 and 2010, nearly half (29, 47.5%) were black or black British.

Child sexual abuse (CSA) is recorded for victims who were under 16 at the time of the offence. Over a third of reported sexual offences were for rape or attempted rape. Just under a third was for sexual assault and taken together all CSA offences accounted for under a quarter of reported sexual offences. There were 147 (9%) reported sexual offences on Merseyside that were classed as domestic violence on the police data during 2008-2010. Of these 147 offences, 20 (13.6%) involved children between the ages of 13-15. Nearly 57% of victims knew their attacker.

Multi-Agency Risk Assessment Conference (MARAC) Data

MARAC is part of a coordinated community response to domestic abuse. All MARAC leads in each Local Authority on Merseyside were asked for data on cases from January 2008-December 2010.

Liverpool are unable to send MARAC data as they have only just started to collect data on sexual violence, therefore they have no cases for this time period and only have four cases at present.

St Helens Community Safety Partnership (CSP) has recognised the need to support and coordinate domestic violence services, and as part of this the CSP has supported the development of RASASC including ISVAs. They sent data on 5 female victims between the ages of 20-41 including three alleged rapes, 1 alleged sexual assault and 1 alleged sexual touching during a domestic violence incident. The rape victims were referred to an ISVA, but one later withdrew their complaint. The sexual assault victim was classed as a high risk domestic violence case that had been discussed at MARAC more than once due to repeat crimes. The last domestic violence case involving sexual touching went to the Crown Court in December 2010.

Discussion

Each adult rape is estimated to cost over £76,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health service and costs incurred in the criminal justice system. The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion.

Addressing the needs of victims early through the provision of SARC's can reduce these costs and deliver benefits to victims in terms of better health, wellbeing and quality of life as well as long term productivity savings in services if the immediate aftermath of sexual assault is managed effectively.

It is accepted that many people who have been subjected to a sexual assault do not feel able to report it to the police in the first instance. Despite the advances made in police practice, this is not always reflected in an individual's expectations, especially when they are traumatised. By calling SPM directly, clients are helped to understand the processes involved in reporting a sexual assault and are informed of the actions that can be taken to minimise the problems that can occur as a result of a sexual assault. The service provides a one stop shop for arranging examinations and other appropriate support whilst providing clients with the confidence to access the help and support needed to enable them to minimise the physical and mental impact of a sexual assault. Wherever possible, SPM staff encourage self-referring clients to go on to report their assault to the police, whilst recognising that the client's choice is final and in some cases they will continue to refuse police involvement. In all cases, clients are assisted to access appropriate support services, in keeping with the SPM mission to improve recovery and long-term prognosis for survivors of sexual assault.

Younger victims of sexual assault under the age of 19 can be referred to the SARC at Alder Hey called the Rainbow Centre. However, SPM is seeing clients who are young teenagers. Many young people see themselves as adults and may have an issue with presenting at a children's hospital. Also, it is not seen as a discrete service as it is common local knowledge what the Rainbow Centre does. Post SARC support after attending the Rainbow Centre and SPM is required for adolescents. There are no specialist ISVA services for adolescents; although RASASC provides counselling for young people and there is now a Child and Adolescent Mental Health Service (CAMHS) team for 17-18 year olds.

Liverpool continues to be the most deprived local authority in the country. Poverty has been linked to being a victim or perpetrator of sexual violence. SPM receives most of its clients from Liverpool and a half of all reported sexual offences in Merseyside are within the Liverpool area. Furthermore, 10 out of 12 wards recording the highest number of sexual violence offences are classed in some of the most deprived areas on Merseyside, including 7 in Liverpool. Six of these 12 wards are situated in a city centre which promotes a night-time economy with access to licensed premises in clubs and public houses. Indeed access to alcohol is a factor in both the perpetration of sexual violence and the risk of being a victim. Sexual offences are the only type of offence on Merseyside that has shown an increase in police recording from 2008/9, which could demonstrate an improved willingness of survivors to report and confidence in the crown prosecution service.

Other factors associated with being a victim of sexual violence are being young, married or cohabitating, involvement in sex work, a history of child sexual abuse, having a mental illness or a learning or physical disability. From the data collected from services, (both quantitative and qualitative) these are recurring themes. However, research looking at disabled people's experiences of targeted violence (including sexual violence) and hostility has found that they usually report incidents to a third party but these organisations do not always alert the police. Indeed, particularly survivors with learning disabilities may have difficulty verbalising their abuse and being believed.

Liverpool has a dedicated ISVA based at Armistead Street, for sex workers and up to December 2010, SPM has received 18 clients who have survived sexual violence related to sex work or trafficking. Through lack of an outreach service, there is no crime prevention for sex workers working in massage parlours and for escorts. There were two rapes reported in January in Liverpool parlours, which has been described as alarming as no indoor rapes have been reported since 1999 in such places.

SPM has reported a substantial increase in self-referral calls to the service since their website went live on 28th February 2011 and this high level has been maintained during April – June 2011. Also, SPM has been receiving more referrals from other health services and related professions who may come into contact with victims, since their website was launched. However, more could be achieved through specialist campaigns. This increase in service delivery requires additional input from support and advocacy services. Coupled with the increased efficiency of the Police Unity Team counselling is now required sooner. Yet services that provide counselling on Merseyside are registered charities chasing diminishing short-term funding opportunities. Furthermore, counselling for men has been described as limited in Liverpool and the Wirral, yet there are huge psychological issues that have to be faced by men and many will fear coming forward and reporting to the police. Although SPM will provide an excellent service for males and will refer appropriately, with or without police involvement, it was the opinion of a service provider, that their publicity may not be explicit enough in male society. However, on their website a separate page is now dedicated to men that seems to have made a difference. Additionally, both the RASA Liverpool ISVA service and the specialist ISVA service for sex workers have been threatened with cuts in financial support from Liverpool Council, due to the economic downturn and cuts in council funding.

Data problems

The main problem with data, apart from some input errors that could be corrected, was that it was not always available on computer software that could be easily shared on a spreadsheet. This made data sharing an extremely time consuming exercise for organisations concerned and if it could be supplied it could be somewhat limited and was not always available for the full requested time period of three years 2008-2010. MARAC data for sexual violence has not been routinely included in easily searchable computer formats, so was only available for one local authority.

For other health services, data on sexual violence is not currently distinguished from other forms of violence. Therefore, trying to ascertain the prevalence of sexual violence on Merseyside from health services is problematical as only a small proportion of victims will present themselves to specialist sexual violence services or the police. Coping with sexual abuse can lead to self-harm, drug and alcohol dependence, loss of self-confidence, depression etc. which creates an added burden to health services. Many sexual assault or rape survivors will report to other services with these problems, but sexual abuse is not being recorded.

The British Crime Service (BCS) estimates that only around half of all crime it measures is captured on police recorded crimes. However, the BCS has some limitations. It only surveys 16 to 59 year olds about their experiences of sexual violence, with a five crimes per person cap, which may not take into account long-term abuse. It also excludes residents of communal establishments such as hotels, nursing and care homes and university halls of residence.

Recommendations

The following recommendations are based on key issues and themes that have been highlighted in this research that would improve the service and facilitate crime prevention.

Promoting the sharing of information

Recording of sexual violence as a separate category from other types of violence on computer software in all health care settings.

Computerisation of sexual violence data in all specialist sexual violence and domestic violence settings. Prior consultation should take place on which data to record so there is consistency of recording across services.

Raising awareness of SARC services

Specialist campaigns are required to raise awareness in other services of SARC services. This would include campaigns for doctors and other health workers, teachers, university/college counsellors, social workers and drug and alcohol teams.

Additional marketing of SARC services, particularly for men, is required in pharmacies, GUM clinics and drug services. The marketing needs to state that men do not have to report to the police.

Advocacy for victims

Disclosure of sexual violence to health workers and other third parties (particularly from disabled victims or those suffering from a mental illness) should be taken seriously to ensure survivors receive the help they require from SARC services and support to report the crime to the police.

The setting up of a dedicated ISVA service for adolescents.

Crime Prevention

To consider the commissioning of an outreach service for sex workers in massage parlours and for those working as escorts.

Safer community partnerships to map sexual violence hotspots in their area, so that appropriate strategies can be developed for prevention. For instance: Safer community partnerships to work with planning departments to encourage a more mixed and diverse night time economy by encouraging other types of businesses to open.

Background to the project

Nationally there has been much attention given to the provision of sexual assault services. Standards of care and provision vary widely across the country, with some areas having little or no access to services.

Currently across Merseyside the provision of Sexual Assault Referral Centre (SARC) services is split between two providers. Children who have experienced rape or sexual assault are taken to the Rainbow Unit at Alder Hey Children's Hospital for assessment and care. SAFE Place Merseyside (SPM) has been operational for nearly two years and provides on call care and treatments for adults and older children from across Merseyside.

Liverpool Public Health Observatory (LPHO) has recently completed a review of the Safeguarding provision for children in Merseyside. Unfortunately, an opportunity was missed as the review only looked at children and not the provision for adults. A view is required of the total need across Merseyside for people of all ages. There are obvious areas of cross over where for example young people (legally classed as children) may prefer to access more adult services.

The findings from this review will inform the strategic review of the commissioning arrangements for the provision of SARC services for the population of Merseyside. It will ensure that all people will receive optimum high quality care when they need it, not being dependent on their age or area of residence within Merseyside.

Objectives

- To review the current activity in sexual violence services in Merseyside over the past three years (January-December 2008-2010) including seasonal variation, (or past two years in the case of SAFE Place Merseyside (SPM), which opened in September 2008) for those aged 13 years and above.
- A review of the actual need; utilising data from Police, 3rd Sector and health and social care agencies.
- To ensure that provision meets actual need and to reduce organisation barriers.
- To ensure that provision is safe, efficient and affordable. Currently the governance and accountability arrangements for each of the services that work together to form the SARC (Police, Liverpool Community Health, Forensic medical Examiners and 3rd sector support agencies RASA and RASASC) are inconsistent.

Methods

- Building upon the existing work by LPHO, a multi agency steering group was formed to enable the collection of data from police and health and social care agencies across Merseyside. The steering group was answerable to Merseyside commissioners on a regular basis.
- Review available qualitative and quantitative data including all activity relating to sexual violence against victims 13 years and above on Merseyside showing the need versus current provision for such sexual violence services.
- Make recommendations on current provision, linking to national standards for SARCs, to inform commissioning of better outcomes for all, considering equity and most efficient use of resources.

Communication plan

Interested Parties

- Merseyside commissioners – sexual health and children
- Merseyside Police
- 3rd Sector Organisations
- SAFE Place Merseyside staff
- Rainbow Centre staff
- Local Authorities
- Crime and Disorder Reduction Partnerships

Method of Communication

Written and verbal presentations to strategic groups

Population Profile for Merseyside

Age/sex

Table 1: Population of Merseyside 13 and over by gender and age-group

		13-20	21-30	31-40	41-50	51-59	60+	Total by gender	Total in LA
Knowsley	M	8,502	9,776	8,530	10,592	7,870	13,539	58,809	125,516
	F	8,406	9,949	9,757	12,528	8,684	17,383	66,707	
Liverpool	M	26,141	44,361	26,745	28,795	21,956	38,202	186,200	381,464
	F	26,183	41,581	26,085	30,715	23,545	47,155	195,264	
St Helens	M	9,578	10,326	11,144	12,720	10,106	18,989	72,863	151,001
	F	9,202	10,564	11,746	13,284	10,351	22,991	78,138	
Sefton	M	14,735	15,469	13,589	19,657	15,812	31,889	111,151	235,910
	F	14,203	14,353	15,438	21,916	17,065	41,784	124,759	
Wirral	M	16,198	17,482	16,443	20,794	17,409	34,726	123,052	261,431
	F	15,182	17,039	18,644	24,149	19,002	44,363	138,379	
Total		148,330	190,900	158,121	195,150	151,800	311,021	1,155,322	1,155,322

Source: ONS 2009 population estimates analysis tool

From the ONS population estimates for 2009 there were 1,155,322 people of 13 years and over on Merseyside, which consists of 552,075 (47.8%) males and 603,247 (52.2%) females.

Ethnicity

Table 2: Ethnic composition of Merseyside population 13 +

Local Authority	White	BME	
Knowsley	123,248 (97.4%)	3,288 (2.6%)	126,536
Liverpool	343,519 (91.7%)	31,055 (8.3%)	374,574
St. Helens	147,981 (98)	3,018 (2)	150,999
Sefton	231,561 (97.4)	6,063 (2.6)	237,624
Wirral	256,110 (97.3)	7,036 (2.7)	263,146
Totals	1,102,419 (95.6)	50,460 (4.4)	1,152,879

Source: Mid-2007 Population Estimates by Ethnic Group (February 2010 release), ONS

On Merseyside only 4.4% of the population 13 years and over are from black minority ethnic (BME) groups. The largest percentage of people living in BME groups is resident in Liverpool (8.3%) whilst less than 3% of the population in other Merseyside local authorities are from BME groups.

Table 3: Composition of the minority ethnic population aged 13+

Local Authority	Mixed	Asian or Asian British	Black or Black British	Chinese or other Ethnic Group	Totals
Knowsley	1,146	826	588	728	3,288
Liverpool	6,153	8,600	7,180	9,122	31,055
St. Helens	706	1,108	427	777	3,018
Sefton	1,496	2,001	1,018	1,548	6,063
Wirral	1,612	2,340	1,072	2,012	7,036
Totals	11,113	14,875	10,285	14,187	50,460

Source: ONS mid-2007 population estimates

The largest proportion of the minority ethnic population aged 13 plus on Merseyside is made up of Asians closely followed by Chinese or other ethnic group.

Deprivation

Table 4: Merseyside LA District indicators of Deprivation 2007

Local Authority	Rank of Overall IMD Score	% of SOAs within the 20% most deprived
Liverpool	1	67.7
Knowsley	5	63.6
St Helens	47	36.4
Wirral	60	32.8
Sefton	83	25.8

Source: IMD 2007

The Index of Multiple Deprivation (IMD) provides a measure of relative deprivation across England. It combines a number of indicators chosen to cover a range of economic and social issues, into a single deprivation score for each small area in England (SOAs). This allows each area to be ranked relative to one another according to their level of deprivation. For the local authority district level in Table 11, the lower the rank the more deprived the area with a rank of 1 being the most deprived out of 354 local authorities in England. The Indices of Deprivation 2007 have been produced at Lower Super Output Area level (SOA), of which there are 32,482 in England. SOAs have a population of between 1,000 and 2,000 compared with ward areas which are much larger (population of between 800 up to 35,000).¹

The IMD 2007 shows that Liverpool continues to be the most deprived local authority in England, with nearly 56% of Liverpool's residents living in an area that is ranked within the most deprived 10% and 68% living in the most deprived 20% in the country. Spatially the North Liverpool area which consists of four wards: Anfield, County, Everton and Kirkdale stand out with 90% of its SOAs falling within the most deprived 10% nationally. In contrast, only 27% of the SOAs in the South Central area of Liverpool fall within the most deprived 10%.²

Knowsley is the fifth most deprived local authority in the country where 46% of the population live in communities classed as being within the 10% most deprived in England in relation to overall deprivation. Although deprivation within Knowsley is high, levels vary considerably between the most deprived and the least deprived communities. Page Moss, Longview, Northwood and Stockbridge are the most deprived in terms of overall deprivation with Halewood North, Roby, Swanside and St Bartholomews being the least deprived wards.³

In St Helens there are 27 SOAs which fall into the most deprived 10% nationally and 43 SOAs in the most deprived 20%. There is a cluster of SOAs falling within the most deprived 5% nationally in the Town Centre, Parr, Thatto Health and Bold with other pockets of high deprivation in Windle and Newton.⁴

On the Wirral nearly a third of SOAs fall within the 20% most deprived nationally, however there are sharp contrasts. The SOAs experiencing the most severe levels of multiple deprivation are in the east of Wirral predominantly in the docklands areas i.e. Bidston, Birkenhead, Tranmere and Seacombe. SOAs experiencing some of the lowest levels of deprivation are in the more affluent areas to the west of Wirral, although some pockets of deprivation also exist within these areas.⁵

Sefton is the least deprived of the Merseyside local authorities, with just over a quarter of its SOAs falling within the 20% most deprived nationally. Like the Wirral it too is a borough of contrasts. It has concentrated areas of extreme deprivation coinciding with the most densely populated, urban centres of Bootle and to a lesser extent Southport. This deprivation is counteracted by areas of low deprivation in and around the prosperous suburban wards of Harington, Ravenmeols, Meols and Blundellsands.⁶

Definition of sexual violence and child sexual abuse

Sexual violence has been defined as:

'Any behaviour perceived to be of a sexual nature which is unwanted and takes place without consent or understanding'⁷

Child sexual abuse (CSA) is:

'...unwanted sexual contact of someone under the age of 18. If the contact is consensual, it is considered sexual abuse if the offender is in a position of authority or power by virtue of age or position.'⁸

Contact sexual abuse is defined as any sexual activity (such as touching and penetration) where a) the activity is forced or coerced b) the child is under 16 and the act involves an adult over 18 or c) the child is under 18 and the act involves a parent or guardian or person in a position of trust (as defined by the Sexual Offences Act 2003). It does not include sexual activity between young people aged under 18, if the acts are not forced or coerced.⁹

Sexual Violence Legislation

Sexual Offences Act 2003

The Sexual Offences Act legislation 2003 (that came into force on 1 May 2004) provides a clear framework to protect adults and children from sexual crimes. It strengthens protection around consent, rape, and assault by penetration, sexual assault, causing a person to engage in a sexual activity without consent, administering a substance with intent, other "intent" offences.

It clarified the law on 'consent' which now has a legal definition. It created new offences to help protect adults against 'date rape' drugs, protecting children from exposure to indecent text messages, and online and offline 'grooming'. All sexual offences now apply equally to males and females of any sexual orientation.

There are two sub-categories depending on the seriousness of the crime:

- Most serious sexual crime (including rapes, sexual assaults, and sexual activity with children).
 - **Rape:** A person commits rape if he intentionally penetrates the vagina, anus or mouth of another person with his penis, without their consent.
 - **Serious sexual assault:** Assault by penetration - a person commits assault by penetration if he intentionally penetrates the vagina or anus of another person with a part of the body or anything else, without their consent.
 - **Sexual assault:** A person commits sexual assault if they intentionally touch another person, the touching is sexual and the person does not consent.
- Other sexual offences (including soliciting, exploitation of prostitution, and other unlawful sexual activity between consenting adults).¹⁰

The British Crime Survey

The British Crime Survey (BCS) is a systematic victim study, carried out on behalf of the Home Office. The BCS seeks to measure the amount of crime in England and Wales by asking around 50,000 people aged 10 and over (as of January 2009), living in private households, about the crimes they have experienced in the last year.

The value of the BCS is that it can provide a better reflection of the true level of crime than police statistics since it includes crimes that have not been reported to, or recorded by, the police. The BCS estimates that only around half of all crime it measures is captured on police recorded crimes largely because people do not bother to report crimes because they think the crime was too trivial or the police are unable to do much about it. The BCS also provides a better measure of trends over time since it has adopted a consistent methodology and is unaffected by changes in reporting or recording practices.

The BCS has weaknesses as it has five crimes per person cap, which may not take into account long-term abuse such as domestic violence. It also excludes residents of communal establishments such as hostels, nursing and care homes and university halls of residence.

Due to sensitivity of reporting in the context of a face-to-face interview, the main BCS crime count does not include rape and other sexual offences. However, it does provide estimates of the proportion of adults (aged 16-59) who have been a victim of such offences, which are obtained through a supplementary set of questions answered by self completion outside the main interview. This shows that, according to the 2009/10 BCS, **approximately two per cent of women aged 16 to 59 and less than one per cent of men (of the same age) had experienced a sexual assault (including attempts) in the previous 12 months.** The majority of these are accounted for by less serious sexual assaults. There were no changes in the overall prevalence of sexual assaults between 2008/09 and 2009/10.¹¹

Table 5: Prevalence of sexual offences among 16-59 year olds in the past year based on the British Crime Survey 2009/10

Category of Sexual Offence (as per British Crime Survey)	Respondents from BCS			Estimated number for Merseyside per year*
	Men % victims in past year	Women % victims in past year	All % victims in past year	
Any sexual assault (including attempts)	0.5	2.3	1.3	10,335
Serious sexual assault (including attempts)	0.1	0.4	0.2	1,590
Serious sexual assault	0.0	0.3	0.2	1,590
Rape (including attempts)	0.0	0.4	0.2	1,590
Rape	0.0	0.3	0.2	1,590
Assault by penetration (including attempts)	0.0	0.1	0.1	795
Assault by penetration	0.0	0.1	0.1	795
Less serious sexual assault	0.4	2.1	1.3	10,335

Source: *British Crime Survey 2009/10*

*Based on ONS 2009 population estimates analysis tool

Since the British Crime Survey (BCS)¹¹ only surveys 16 to 59 year olds about their experiences of sexual violence, this is the only age-group for whom estimates on numbers affected on Merseyside can be made. According to the ONS 2009 population estimates the Merseyside population aged 16-59 equates to 795,030.

The category of serious sexual assault used in the BCS self-completion module includes incidents of rape and assault by penetration. The 2009/10 BCS self-completion module showed that 0.1 per cent of men and 0.4 per cent of women had been the victim of a serious sexual assault (including attempts) in the year prior to interview. These estimates were not significantly different compared with the 2008/09 BCS.

According to the 2009/10 BCS, 0.2% of respondents declared that they had experienced a serious sexual assault in the past year. This equates to 1,590 individuals in the 16 to 59 age bracket across Merseyside. The same percentage of respondents reported that they had been raped in the previous year, but whereas serious sexual assault or attempted serious sexual assault was experienced by both genders, the survey only detected female survivors of rape. The data for men as compared to women shows only 0.5% of men experienced some form of actual or attempted sexual assault in the previous year as compared with 2.3% of women.

Table 6: Estimated numbers aged 16-59 by Local Authority on Merseyside that could have been a victim of sexual assault (including attempts) each year

	Population 16-59*		Merseyside Police reported sexual offences For year 2010		Est. No. Of victims of any sexual assault (including attempts) per year		Est. No. Of victims of serious sexual assault (including attempts) per year	
	Males	Females	Males	Females	Males (0.5%)	Females (2.3%)	Males (0.1%)	Females (0.4%)
Knowsley	42,335	46,289	1	29	212	1,065	42	185
Liverpool	140,682	141,383	17	190	703	3,252	141	566
St Helens	50,360	51,722	4	54	252	1,190	50	87
Sefton	73,933	77,808	1	47	370	1,790	74	311
Wirral	82,214	88,304	3	94	411	2,031	82	353
Merseyside	389,524	405,506	26	414	1,948	9,327	390	1,622

Sources: Liverpool CitySafe; British Crime Survey 2009/10

*Based on ONS 2009 population estimates analysis tool

Table 6 shows the estimated numbers of 16-59 year olds in each Merseyside Local Authority that could be a victim of sexual assault each year. The estimated number of victims of any sexual assault (which includes victims of serious sexual assault) is mainly composed of less serious sexual assault. For Liverpool alone this shows that 703 males and 3,252 females are at risk of a sexual assault in any year and 141 males and 566 females are at risk of a serious sexual assault each year. However, in Liverpool the recorded sexual offences in 2010 for those aged 16-59 were 17 for males and 190 for females, which represent only 29.3% of serious crimes reported in the British Crime Survey.

Table 7: Prevalence of victims once or more among 16-59 year olds based on the British Crime Survey 2009-10

Category of Sexual Offence (as per British Crime Survey)	Respondents from BCS			Est. No. aged 16-59 in Merseyside victims once or more*
	Men % victims once or more since 16	Women % victims once or more since 16	All % victims once or more since 16	
Any sexual assault (inc. attempts)	2.3	19.7	10.9	86,658
Serious sexual assault (inc. attempts)	0.3	5.1	2.7	21,466
Serious sexual assault	0.2	4.3	2.2	17,490
Rape (inc. attempts)	0.3	4.7	2.5	19,876
Rape	0.2	3.8	2.0	15,901
Assault by penetration (inc. attempts)	0.1	1.8	0.9	7,155
Assault by penetration	0.1	1.5	0.8	6,360
Less serious sexual assault	2.2`	19.0	10.5	83,478

Source: British Crime Survey 2009/10

*Based on ONS 2009 population estimates analysis tool

According to the BCS, 10.9% of the population aged 16 to 59 has been a victim of some form of sexual assault or attempted sexual assault as adults. Applied to the population of Merseyside this equates to 86,658 individuals in this age-group who have a history of sexual assault as an adult.

The figure of 2% of those aged 16 to 59 who responded that they had been raped since the age of 16 equates to 15,901 across Merseyside.

Nationally Recorded Crime from Home Office Statistics for England and Wales

There were 54,509 sexual offences recorded by the police in 2009/10, a 6% increase compared with 2008/09. This increase needs, however, to be interpreted with caution. The Association of Chief Police Officers (ACPO) has been taking steps to enhance the recording of serious sexual offences and this has culminated in inclusion of good practice guidance in the Home Office Counting Rules for crime from April 2010. While these were not formally in place in 2009/10, it may well be that figures for 2009/10 reflect initiatives undertaken by forces over the last year as they anticipated their introduction.¹¹

The police recorded crime category of most serious sexual crime encompasses rape, sexual assault, and sexual activity with children. The Sexual Offences Act 2003, introduced in May 2004, altered the definitions of these offences, affecting long-term trends in these figures. The police recorded 43,579 most serious sexual offences in 2009/10, a seven per cent increase compared with the 40,748 recorded in 2008/09. Most serious sexual offences accounted for 80 per cent of total sexual offences and one per cent of all recorded crime in 2009/10. Within this total, police recorded rapes of a female increased by 15 per cent to 13,991 offences, and sexual assaults on a female increased by one per cent to 19,873 offences. For serious sexual offences for males during 2009/10: rapes increased by 22 per cent to 1,174 offences and sexual assaults decreased by two per cent to 2,270 offences. These increases may be affected by steps forces have been taking to improve their recording of sexual offences. However, for England and Wales there was a decrease of 30% of recorded sexual assaults that involved knives or sharp instruments from 134 in 2008/9 to 94 in 2009/10.

On Merseyside during 2009/10 there were 923 recorded sexual offences this represents 0.9% of all reported offences (107,730) within the region and a 13% increase in sexual offences from 2008/9. In fact sexual offences are the only type of offence on Merseyside that has shown an increase in police recording from 2008/9. There was a decrease from 4 to 3 sexual offences on Merseyside involving knives or sharp objects from 2008/9 to 2009/10.¹¹

Factors associated with sexual violence

Table 8: Risk factors associated with sexual violence from research

Factors increasing vulnerability for individual	Factors increasing risk of committing sexual violence
Being young	History of Child Sexual Abuse
Previously been sexually assaulted when young	
Deprivation - poverty	Poverty – income inequality
Being married or cohabitating	Social norms – male sexual entitlement
Consuming alcohol or drugs	Alcohol & drug consumption
Involvement in sex work	
Mental illness, learning and physical disability	

A risk factor is an attribute, characteristic or exposure that increases the chances of something happening. The above table lists the frequently reported factors that are associated with increased risk of sexual assault occurring. Research suggests that these various factors have an additive effect, so that the more factors present, the greater the likelihood of sexual violence.

Young age

Figures from justice systems and rape crisis centres show children and youths are at a greater risk of sexual assault and one third to two-thirds of all victims are aged 15 years or less.¹² Young women are usually found to be more at risk of rape than older women.¹³ Indeed 54% of female rape victims identified by a US national survey were younger than 18 when they experienced their first attempted or completed rape.¹⁴

From all reliable studies there is consensus that girls experience more sexual abuse than boys. A prevalence study in the UK of 2,869 young people aged 18-24 with a response rate of 69% found that 21% of females and 11% of males had experienced child sexual abuse (CSA).¹⁵ A meta-analysis of 22 randomly sampled prevalence studies estimated that the prevalence for female CSA was 30% to 40% and for males was 3% to 13% in North America.¹⁶ This shows the possible magnitude of the problem.

Increased vulnerability and diminished likelihood of disclosure and prosecution appear to be primary reasons children suffer high rates of sexual assault. They are particularly vulnerable to sexual abuse by those in a position of trust. Knowing their perpetrator they will thus find it difficult to disclose the abuse putting them at risk of chronic sexual abuse.¹³

Having previously been sexually assaulted when young

There is some evidence that experiencing sexual abuse in childhood or adolescence is a risk factor for sexual victimisation during adulthood.¹³ Women with a childhood history of sexual abuse are 4.7 times more likely to be subsequently raped.¹⁷

Evidence suggests that sexual violence is a learnt behaviour in some men. Studies on boys with a history of CSA have shown one in five continue in later life to molest children themselves.¹⁸ Therefore, continuing the cycle of abuse.

Poverty

Poverty is linked to both the perpetration of sexual violence and the risk of being a victim.¹² While sexual assault does occur in upper middle and lower socioeconomic areas it is more prevalent in lower socioeconomic areas.¹⁹ Although childhood sexual abuse also occurs among all socio-economic groups, more severe forms are associated with lower socio-economic status.²⁰

Research shows an undeniable, complex and often cyclical connection between sexual violence and poverty. Sexual violence can jeopardize a person's economic wellbeing, often leading to homelessness, unemployment, interrupted education and health, mental health problems, and other daily stressors and struggles. In turn, poverty increases the risk of sexual violence; it can make women and children more dependent on others for survival and, therefore, less able to control their sexual safety, to consent to sex, and to meaningfully address their own victimisation. Sexual violence increases the risk of poverty by undermining employment and interrupting education.²¹ There are a high number of sexual assaults amongst the homeless. In one study 13% of homeless women reported having been raped in the previous 12 months, and 50% of these women were raped twice.²²

There may be a link with the level of income inequality in a country. The evidence that violent crime is higher in countries, like the UK and USA, where there are bigger income differences between rich and poor has continued to accumulate. These results persist despite cultural variations. Several researchers have argued that poverty and the perpetration of sexual violence is mediated through forms of crisis of masculine identity.²³ ¹² Income inequality makes people more sensitive to experiences of inferiority such as disrespect, loss of face and humiliation which are amongst the most common triggers to violence.²⁴

Being married or cohabiting

One of the most common forms of sexual violence is that which is perpetuated by an intimate partner, thus one of the most important risk factors of sexual assault for women is being married or cohabiting with a partner.¹² Patriarchy, tradition, culture, and religion make many women feel they must remain silent about such abuse. Statistics in the United States show that 10%–14% of women ever married have been raped at least once. A survey on gynaecological patients in Norway indicates that 25% of patients have been sexually abused by their intimate partner. In addition, 25% of married women interviewed in the Netherlands stated that they had been forced into unwanted sex with their spouses.²⁵

Social Norms of male entitlement

Sexual violence can be directed to and perpetrated by both men and women. However, the vast majority of perpetrators are male and the victims are in most cases female. Although, under the terms by which rape is defined in law only males can be the perpetrators as the act of rape requires a penis. "Male rape" was only classed as a crime under the 1994 Criminal Justice and Public Order Act. Also comparatively little research has concentrated on male experiences of sexual assault

and the precise prevalence and incidence evidence on male rape remain under-investigated. Furthermore, many accounts of male rape suggest that experiences for men have particular stigma attached to them and that this additional stigma may explain the small numbers of reported male rapes.²⁶

The social environment within a community that is deeply entrenched in a community belief in male superiority and male entitlement to sex will greatly affect the likelihood of sexual violence taking place, as will the general tolerance in the community of sexual assault.¹²

Consuming alcohol and drugs

Across disparate populations studied, approximately 50% of all sexual assaults are committed by men who have been drinking alcohol. Similarly, approximately 50% of all sexual assault victims report that they were drinking alcohol at the time of the assault.^{27 28} Alcohol consumption could be related to sexual assault through multiple pathways. Men who drink heavily are also likely to do so in social situations that frequently lead to sexual assault. Heavy drinkers may routinely use intoxication as an excuse for sexual assault.^{29 30} Certain personality characteristics (e.g. impulsivity and antisocial behaviour) may increase men's propensity both to drink heavily and to commit sexual assault.³¹ Alcohol has an effect of reducing inhibitions, clouding judgements and impairing the ability to interpret cues.²⁸ Alcohol could contribute to women taking risks that they normally would avoid, misinterpreting cues and being unable to resist sexual assault.^{29 32} At the same time drinking alcohol can place women in situations where their chances of encountering a potential offender are greater.²⁷ It seems that drugs that reduce inhibition, such as cocaine, will have similar relations to those of alcohol with sexual assault.²³

The North West Public Health Observatory has produced profiles for each Local Authority and Primary Care Trust to show the proportion of sexual crimes that are attributable to alcohol.³³ Local Alcohol Profiles for England (LAPE) indicators use 'attributable fractions' (AFs) to estimate the number of sexual crimes attributable to alcohol consumption. The alcohol-attributable fraction shows the proportion due to alcohol (i.e. 1=100%, 0.25=25% of sexual crimes are due to alcohol).

The AFs were taken from the Home Office New English and Welsh Arrestee Drug Abuse Monitoring System (NEW-ADAM) arrestee survey (1999-2001) and are based on urine tests of arrestees. For sexual offences, the AF is 0.13; meaning alcohol is a factor in 13% of sexual offences. This fraction is then applied to the total number of sexual offences recorded in each area. However the accuracy of this figure may be distorted as it is only estimated from the minority of offenders who have been arrested and urine tested following a sexual crime.

Table 9: Sexual crimes attributable to offender alcohol intake in Merseyside 2009/10

PCT	Number	Crude rate per 1,000 population	Lower 95% CI	Higher 95% CI
Knowsley	7	0.05	0.02	0.10
Liverpool	53	0.12	0.09	0.16
St Helens	11	0.06	0.03	0.11
Sefton	23	0.08	0.05	0.13
Wirral	24	0.08	0.05	0.12

Source: Local Alcohol Profiles for England

Table 10: Sexual crimes attributable to alcohol by Local Authority

PCT	Crimes attributable to alcohol: Crude rate per 1,000 population (2009/10)
Knowsley	0.05
Liverpool	0.12
St Helens	0.06
Sefton	0.08
Wirral	0.08
Blackpool	0.23
Manchester	0.24

Source: Local Alcohol Profiles for England

In the above table local authorities are highlighted according to how they compare to national figures. Local authorities across the country are ranked, and split into 25% bands, referred to as quartiles. Authorities in green, such as Knowsley, St Helens and Wirral are in the best quartile with the lowest rates, Sefton in yellow is in the second best, Liverpool in orange are in the second worst, and those in red are in the worst quartile. Therefore, Manchester and Blackpool are amongst those local authorities in the North West in the quartile in England with the highest rate of sexual crimes attributable to alcohol.³³ The Local Alcohol Profiles does not include data of victims' alcohol intake.

Involvement in sex work

Economic vulnerability and limited career options are significant factors in recruitment into sex work. In one study 84% (109/130) reported current or past homelessness.³⁴ A review of research and clinical reports has reported that from 60% to 90% of those in sex work were sexually assaulted in childhood.³⁵ A number of authors have documented and analysed the sexual and physical violence which is the normative experience for women in sex work. One study that interviewed 16 street sex workers found that 94% had experienced some form of sexual assault; and 75% had been raped.³⁶ In another study of 130 sex workers, 82% reported physical assault since entering sex work and 68% reported rape.³⁴ For women who are sex workers, rape is as traumatic as it is for other women. It may even be more painful, as the act reopens old wounds and buried memories of unbearable abuse. Indeed, sex workers demonstrate many of the same characteristics as soldiers returning from the battlefield with post-traumatic stress disorder.³⁷

Mental illness, learning and Physical Disability

Disabled people, are reported to be four times more likely to experience sexual violence.^{38 39} Yet there is severe under-reporting of incidents. Disabled people have a tendency to report incidents to a third party (e.g. housing officers, local council, teachers, psychiatrist and hospital staff) rather than to the police. Yet these third parties are unlikely to report to the police. Indeed, particularly survivors with learning disabilities or mental health conditions may have difficulty verbalising their abuse and being believed.⁴⁰

The literature identifies heightened risk for disabled children and young people, and for disabled women. The rates of physical and sexual abuse for disabled children are also higher in comparison to non-disabled children.⁴¹ Women with particular mental health conditions such as schizophrenia or bipolar disorder were found to be at a greater risk of rape in comparison with the general population.⁴² Women with learning disabilities are identified specifically in the wider literature as being at risk, with levels of violence against women reported to be greater than against men with similar impairments. For instance, more than 70% of women with 'developmental disabilities' are sexually assaulted, a rate that is 50% higher than women that do not have 'developmental disabilities'.⁴³ However, people with learning impairments may have their choice removed about whether to report an offence to the police and it may be more likely that it is reported for them.⁴⁴ In one study 71% of people with mental health issues had been a victim of crime in the past two years; 27% experienced sexual harassment and 10% experienced sexual assault.⁴⁵

Costs of sexual violence

The wider effects of sexual violence and abuse may be seen in the impact upon victims' families and community fear of crime: women are more worried about rape than any other crime. There is a burden to society from lost output and the long-term health issues faced by victims and the costs associated with these fall mainly on the NHS.⁴⁶ Sexual offences make up 23% of the estimated total cost of crime against individuals and households, the physical and emotional impact being the most costly.⁴⁶

Each adult rape is estimated to cost over £76,000 in its emotional and physical impact on the victim, lost economic output due to convalescence, early treatment costs to the health service and costs incurred in the criminal justice system.^{46 47} The overall cost to society of sexual offences in 2003-04 was estimated at £8.5 billion.

Addressing the needs of victims early through the provision of Sexual Assault Referral Centres (SARCs) can reduce these costs and deliver benefits to victims in terms of better health, wellbeing and quality of life as well as long term productivity savings in services if the immediate aftermath of sexual assault is managed effectively.⁴⁸

National Standards for SARCS

The term ‘SARC’ does not just refer to a building, but embraces a concept of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways.⁴⁸

The Revised National Service Guide⁴⁸ highlights the minimum elements essential for providing high-quality SARCS for victims of sexual violence and sexual abuse, including forensic medical examination.

Table 11: Key elements of a SARC

Elements	Details
1. Twenty-four hour access	Including arrangements for self-referrals, to crisis support, first aid, safeguarding, and specialist clinical and forensic care in a secure unit.
2. Crisis Workers	Appropriately trained to provide immediate support to the victim and significant others where relevant, throughout the examination process.
3. Choice of gender of physician	Wherever possible
4. Access to forensic physicians	And other practitioners who are appropriate qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.
5. Dedicated, forensically approved premises	
6. The medical consultation includes a risk assessment of harm/self harm	Together with an assessment of vulnerability and sexual health; immediate access to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.
7. Access to an independent sexual violence adviser (ISVA)	To provide support, advocacy and follow-up including support throughout the criminal justice process, should the victim choose that route.
8. Well co-ordinated interagency arrangements	Involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.
9. The SARC has a core team	To provide 24/7 cover for services which meets NHS standards of clinical governance and the European Working Time Directive.
10. A minimum dataset and appropriate data collection procedures in each SARC	

Source: Revised National Service Guide, 2009⁴⁸

Sexual Assault Services in Merseyside

SAFE Place Merseyside

SAFE Place Merseyside (SPM) is a Sexual Assault Referral Centre (SARC) for men and women aged 16 and over. It was opened on Monday 8th September 2008 in Liverpool City Centre. Clients are usually referred by the Police but since 22nd Sept 2009 self-referrals can be made. This service extension was in accordance with a recommendation from the National Support Team (NST) for Response to Sexual Violence.⁴⁹

The Centre provides the provision of a **forensic medical examination**, following a recent sexual assault. Forensic Medical Examiners are provided by Merseyside Police. On arrival at the Centre, clients will be able to access emotional and practical support from a Crisis Worker and will also be given information about how to access further care/counselling and support/advice on various criminal justice options. Clients can choose to have the examination without any further police involvement and still be referred for follow-on care and support. Assessment is also made of the individual's needs and emergency treatment e.g. the client's safety: whether they can go home, HIV and pregnancy risk. **(Element 6)**

The Centre is open on a required basis. Since April 2009, clients are able to speak to a Crisis Worker 24 hours a day, 7 days a week who will provide immediate advice and, if necessary, arrange for a forensic examination to take place. **(Elements 1-2, 4)**

The centre is not equipped or staffed to deal with serious physical injury. All serious injuries and urgent medical conditions should be treated first. If the client's condition is such that they need to remain in Accident & Emergency, or an inpatient ward, the Forensic Medical Examiner can be called out to attend the hospital to undertake the examination.

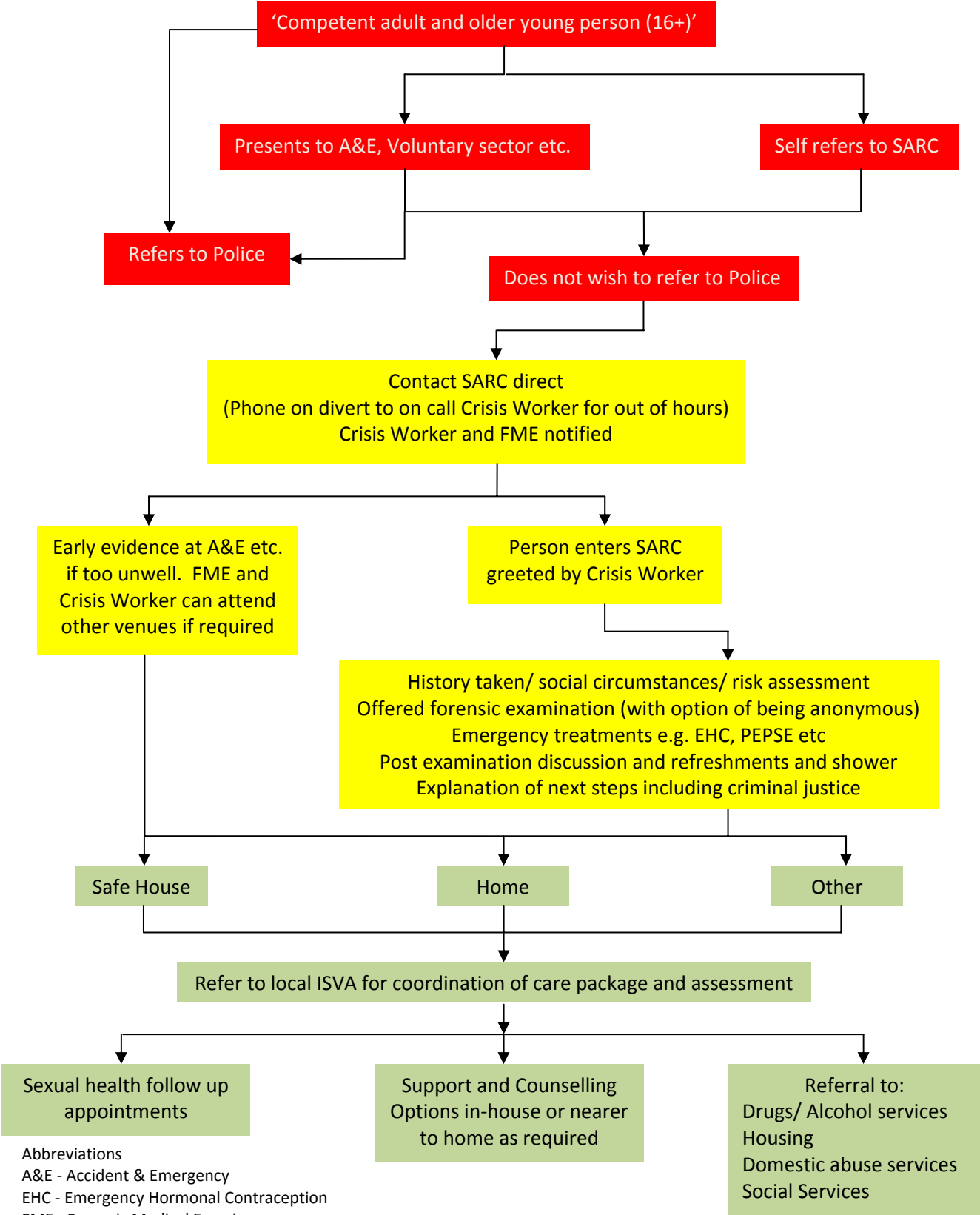
Clients who do not wish to undergo a forensic examination, or those reporting historic assaults (occurring more than seven days ago) would not usually be seen at SPM. An exception may be if there is still evidence of physical injury. If conducted a forensic examination should be undertaken as soon as possible, within the first three days of assault.

All of the key elements of a SARC in Table 7 have been met by SAFE Place Merseyside. However, in the past they have not always had immediate access to Forensic Medical Examiners (FMEs) who are available on a call-out basis. Their FME role at SPM is subject to competing demands from their role as a medical doctor and FME cover at the Rainbow Centre at Alder Hey. (See section on services for children). There is added stress on FME availability during peak holiday periods. For instance, in July 2010 there was only 67% cover. To ease this situation, 6 additional FMEs have been recruited in spring 2011 and will be on the rota to provide this service from October or November 2011 when they have completed their training. It must be stressed that no SPM client's health needs are put at risk as crisis workers are available 24/7 and clients can be examined and treated at either an A & E department or another SARC.⁵⁰

SPM is a joint venture supported by the Home Office, Merseyside Police, Merseyside Police Authority, Liverpool Citysafe Partnership, Merseyside NHS Primary Care Trusts and Local Authorities.

<http://www.safeplacemerseyside.org.uk/home.htm>

Figure 1: Adult Sexual Assault Care Pathway



Abbreviations
 A&E - Accident & Emergency
 EHC - Emergency Hormonal Contraception
 FME - Forensic Medical Examiner
 ISVA - Independent Sexual Assault Advocate
 PEPSE - Post Exposure Prophylaxis following sexual exposure to HIV

Follow-on services

Independent Sexual Violence Advisors are provided through four organisations based in geographical areas.

Independent Sexual Violence Advisor (ISVA)

Following examination, clients may be referred to a local ISVA (**Element 7**) who will co-ordinate after-care packages which may incorporate screening for sexually transmitted infections, counselling, and support throughout any criminal proceedings. ISVA service (and home support) can lessen the need for counselling. Counselling is arranged via the ISVA service, and is not available at the Centre.

Rape and Sexual Abuse Centre (RASA)

RASA offers free and confidential counselling, advocacy and support in a **women only environment**, to female Survivors of Sexual Violence. They have no male employees and on the Wirral they have a safe house that only receives female clients and they have a separate facility that will see male and female clients. Whether it happened recently or years ago, RASA women will listen without judging, support without pressuring and work with the survivor to empower her to take back the control she lost when she was violated.

RASA is an independent voluntary organisation and registered charity that operates from a Safe House in Birkenhead and from Liverpool City centre. It provides a service to Wirral, Liverpool, Sefton, Knowsley, and the Isle of Man, using suitable and appropriate space in other agencies. All their counsellors and support workers have followed extensive RASA training before they begin working with survivors. RASA provides the ISVA service for Liverpool and for the Wirral although RASASC have been commissioned to take SAFE Place Merseyside ISVA Wirral referrals as well. <http://www.rasamerseyside.org>

Rape and Sexual Abuse Support Centre (RASASC)

RASASC (Cheshire & Merseyside) is an organisation committed to supporting people who have been affected by rape or sexual abuse based in St Helens and Newton le Willows. It does not matter how long ago sexual violence occurred or what happened.

They have offices in St. Helens (Merseyside) and Halton (Cheshire) as well as offering outreach support in locations across Cheshire and Merseyside. They have a mixture of volunteers and professional salaried staff working for RASASC who all contribute towards supporting people emotionally, psychologically and practically. The team is highly motivated towards raising society's awareness of the prevalence and consequences of sexual violence as well as helping to challenge common myths and unhelpful perceptions.

RASASC (Cheshire & Merseyside) is a registered charity that started in 1995 and is managed by Trustees and one full-time Operations Manager. It has only been receiving clients from Knowsley and the Wirral for about one year. For their Merseyside clients they have four staff members plus sessional and administrative support.

RASASC aims to provide crucial specialist support, independent advocacy, counselling and information free of charge and in confidence in a safe and non-threatening environment for anyone accessing the service.

RASASC's Services include:

- Counselling and therapeutic work
- Counselling for women affected by rape or sexual abuse
- Counselling for men affected by rape or sexual abuse
- A specialist young person's counselling service
- Counselling for non-abusing family members
- Workshops and group work for various groups of people
- Independent Sexual Violence Advisor (ISVA) services for Wirral, Halton, St. Helen's, Knowsley, Cheshire East and Cheshire West. All clients receive an initial assessment by an ISVA to assess their needs.
- Information about the criminal justice system
- Support and advocacy through the criminal justice system
- Support to apply for Criminal Injuries compensation
- Information and advice about health needs and options
- Support to attend related appointments
- Emotional support
- Highlighting need and referring onto other, more appropriate, agencies
- Liaising with other agencies involved e.g. Independent Domestic Violence Advocates (IDVA)
- Raising awareness
- Maintaining links with agencies who have similar aims locally, nationally and internationally
- Displaying information at events in the community
- Raising awareness of issues relating to sexual violence in the community
- A sexual violence consultation service to local, national and international agencies
- Collation of sexual violence statistical information to be used locally and nationally to inform the development and improvement of the service provision
- RASASC have a strong commitment to ensuring that we deliver a quality service and are an organisational member of the British Association of Counselling and Psychotherapy (BACP). In recognition of their commitment to training and development they also hold the prestigious Investors in People standard.

<http://www.rapecentre.org.uk/>

Vulnerable Victims Advocacy Team (VVAT) – Bootle, Sefton

Sefton provides an Independent Domestic Sexual Violence Advisory (IDSVA) service via VVAT, giving advocacy and support to very high risk victims of domestic violence, sexual violence and hate crime. They aim to empower clients through advocacy and provide support:

- To anyone who is a victim of these crimes and whose cases are going through the court/legal process.
- To anybody whose case is going to the Multi-Agency Risk Assessment Conference (MARAC).

- And access to anybody who requires Sanctuary (additional safety and security to their home or future home) to prevent homelessness and repeat victimisation.
- They are not a counselling service but do refer to other agencies such as RASA.

They use a robust risk assessment tool that asks specific questions that uncover sexual abuse that may not have been reported before. Feedback VVAT receives confirms that their clients understand they are getting a professional to help them to manage their risks of sexual abuse and/or domestic violence.

The team is provided through the Crime and Disorder Reduction Partnership and funded through Sefton Council.

<http://www.saynotofear.co.uk/directory/directory-info.asp?service=17&group=2>

ISVA specialist provision for sex-workers

The ISVA operates from **Armistead Street**, an outreach and support service for sex workers across Liverpool, located within the Armistead Centre, Liverpool Community Health Care. Armistead Street is funded by the Home Office to employ an ISVA.

This is the only such post to be funded within a dedicated support service for sex workers.

The ISVA works in partnership with a number of agencies i.e. health, drugs, housing, police and the voluntary sector. She also co-ordinates the Armistead Street "Ugly Mugs" scheme that enables sex workers to report crimes committed against them to the project. The project can then alert other sex workers to potential attackers. Ugly Mugs is also another means of encouraging sex workers to report crimes to the police. The service receives funding from the Home Office and matched funding from Liverpool Citysafe up to the end of March 2011. Liverpool Citysafe is the name of the City's Community Safety Partnership.

<http://www.armisteadcentre.co.uk/>

Services for children (under 16 years)

All children aged 16 or under in the community for whom there are concerns of a serious/specialist safeguarding nature where sexual abuse is suspected are referred directly to the Rainbow Centre at Alder Hey (children's sexual assault referral centre, or SARC) by the local/ area social services department or the police. Most of those aged between 16 and 19, and some aged under 16, will be referred to SPM (the sexual assault referral centre for young people and adults on Merseyside), either by the police, or more recently, self-referral.

All cases identified at district general hospitals (wards, A&E or out-patients) in Merseyside involving child sexual abuse are also referred to the Rainbow Centre.

Joint Police/CPS Unity Team

Merseyside Police have a dedicated Investigative Unit called the 'Unity Team' who will help victims of serious sexual violence. The Unity Team is made up of specially trained police officers (SOLOs) and detectives who investigate reports of serious sexual assault across the Merseyside Police area. The Team is supported by a number of Rape Specialist Lawyers who work alongside the police to ensure that the best possible prosecution case is considered and instigated.

The team of experts from CPS Merseyside on the Unity team share a vast experience of prosecutions, as well as the ability to treat each case with the care and attention it needs. Merseyside CPS has assigned three specialist rape prosecutors, supported by two dedicated paralegal officers, who work with the police from the moment an offence is reported. Their initial priorities are to offer advice to the police on the evidence which might be required and on the most appropriate charges, to ensure that together the Unity team can build the strongest case possible.

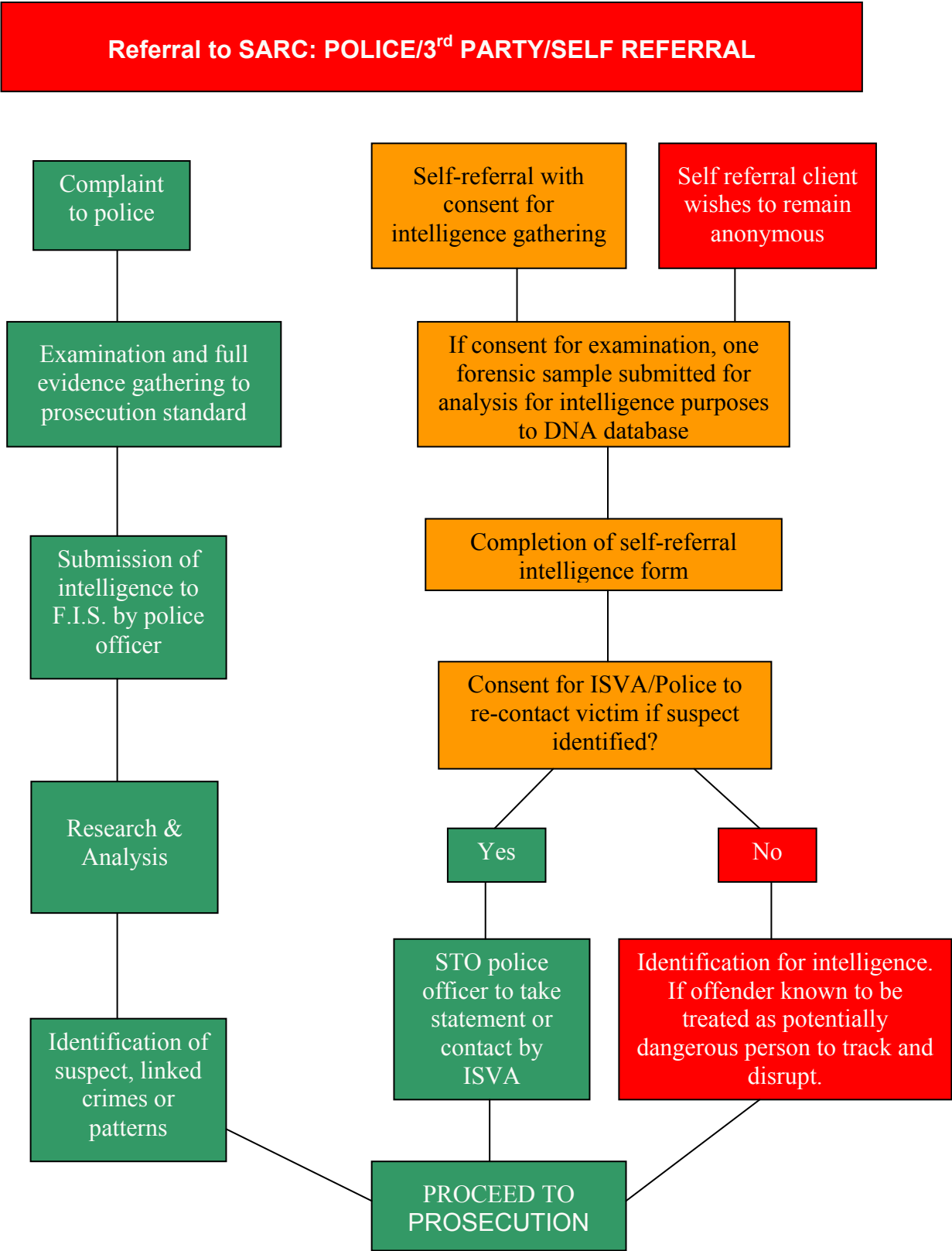
When cases are assessed, CPS prosecutors apply legal tests to ensure decisions are fair and consistent. Firstly they have to decide whether there is enough evidence for a realistic prospect of conviction and, if so, they then decide if the case is in the public interest. These tests are set out in the Code for Crown Prosecutors. Once prosecutors are confident in the evidence and information they have, they will then take things to the next level - getting the case ready for court and working closely with barristers who will present it.

The CPS team will also do all they can to support victims and witnesses. One crucial way is to offer special measures for a victim. For instance, an application can be made to the Court for the witness to give evidence from behind screens to avoid facing the defendant in a court room.

In some cases the prosecution team may meet with the victim during and following a case to discuss the procedures and outcomes. In addition, their specially trained Witness Care Unit provides additional support and advice throughout a case - from reducing the fear of attending court to keeping victims and witnesses informed of developments as the case progresses.

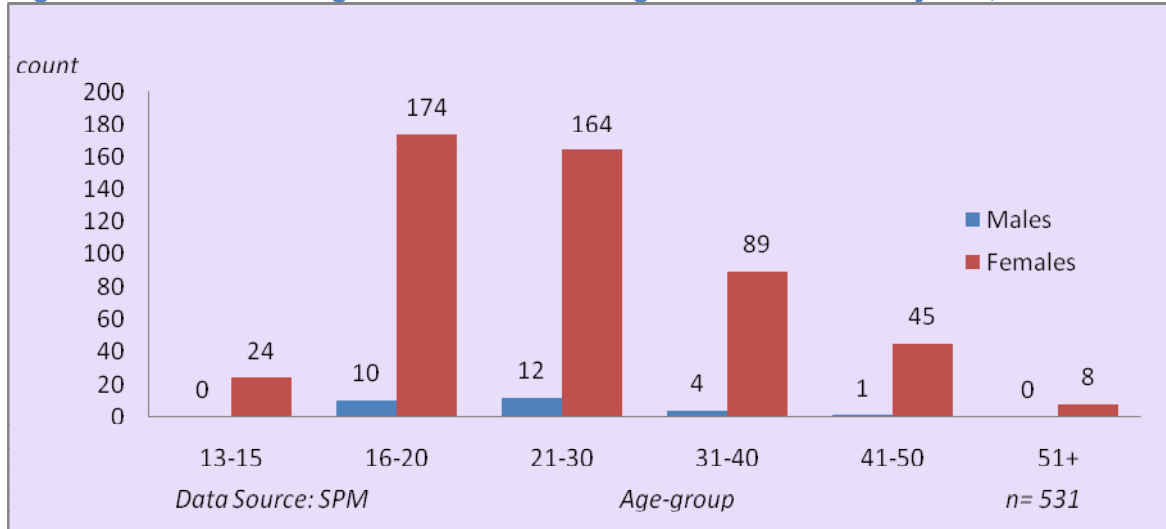
<http://www.merseyside.police.uk/index.aspx?articleid=7566>

Figure 2: Intelligence Flow Merseyside SARC



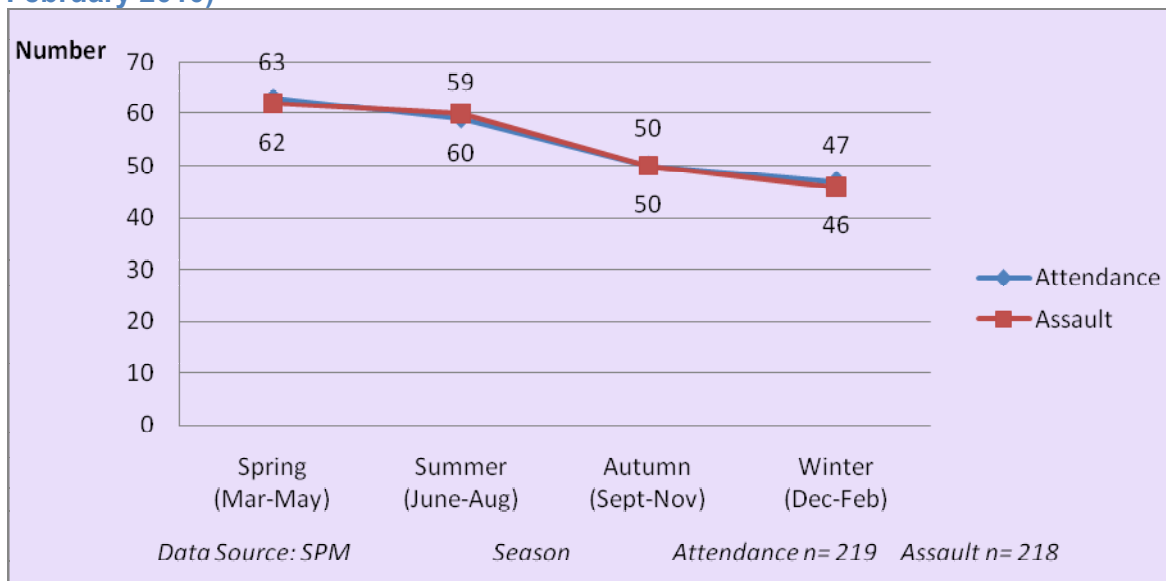
Data from SAFE Place Merseyside

Figure 3: Gender and Age of victims attending SAFE Place Merseyside, 2008-2010



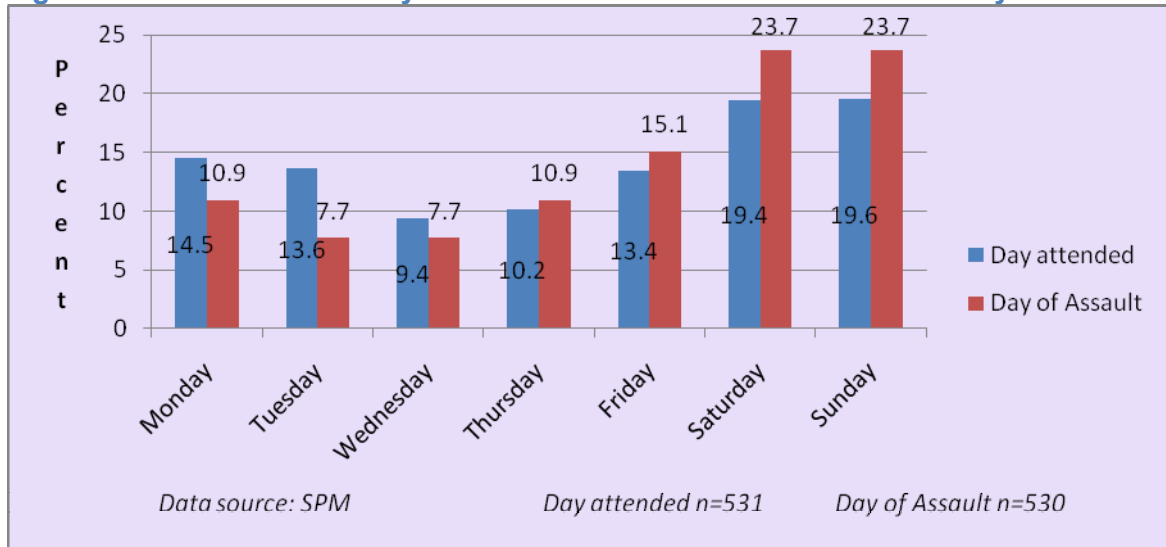
SAFE Place Merseyside (SPM) received its first three clients on Friday 26th September 2008. From September 2008 until the end of December 2010, 531 clients had been seen of which 504 or 95% were female. The majority of attendances (360, 67.8%) came from people aged 16-30. After that age the numbers decline with only 8 attendances from females over 50, including one adult over 60. If the month of September 08 is excluded from the analysis (as it was not a complete month) 522 attendances were recorded. Over this 27 month period this equates to an average of 19 per month.

Figure 4: Seasonal variation: attendances at SPM and month of assault (March 2009 – February 2010)



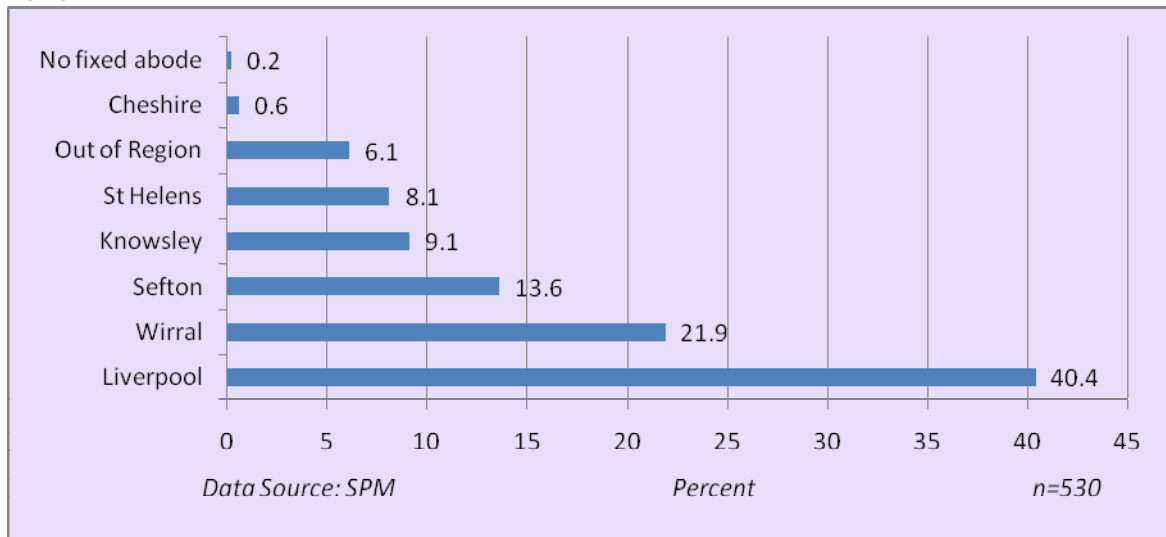
Most attendances (55.6%) at SPM and actually date of assault (55.8%) took place within the warmer spring and summer months.

Figure 5: Attendance and day of assault recorded at SAFE Place Merseyside



Most attendances and assault days fall at the weekend, (39% and 47.4% respectively). This shows a possible link with the night-time economy. Most SARC clients (72.5%) attended either the same day or the day after the assault, with 41.8% attending the same day. The longest a victim took to attend was 25 years and 8 months.

Figure 6: Percentage of SAFE Place Merseyside Clients resident in each PCT 2008-2010



SPM is situated in Liverpool and most clients referred to SPM are resident in Liverpool (214, 40.4%) or the Wirral (116, 21.9%). Only 72 (13.6%) come from Sefton, 48 (9.1%) from Knowsley and 43 (8.1%) from St. Helens. These attendances represent only a small proportion of the total population of 13 years and over living in

each Local Authority on Merseyside: Liverpool 0.06%, Wirral and Knowsley each have 0.04%, Sefton 0.03% and St. Helens 0.02%.

Table 12: Composition of the minority ethnic clients of SPM aged 13 and over 2008-2010 number (%)

Local Authority	Asian/ Asian British	Black/ Black British	Mixed	Other	Total
Liverpool	1 (5.3)	7 (36.8)	11 (57.9)	0	19 (100)
Sefton	0	0	2 (100)	0	2 (100)
Wirral	0	0	2 (66.7)	1 (33.3)	3 (100)
Out of Region	0	1 (100)	0	0	1 (100)

Source: SPM

Data on ethnicity and PCT of residence was available for 99.1% (526) of clients. Of the 25 clients recorded as Black and Minority Ethnic (BME) attending SPM between end of September 2008 and 2010, almost all (19, 76%) were from Liverpool. There were 2 from Sefton and 3 from the Wirral.

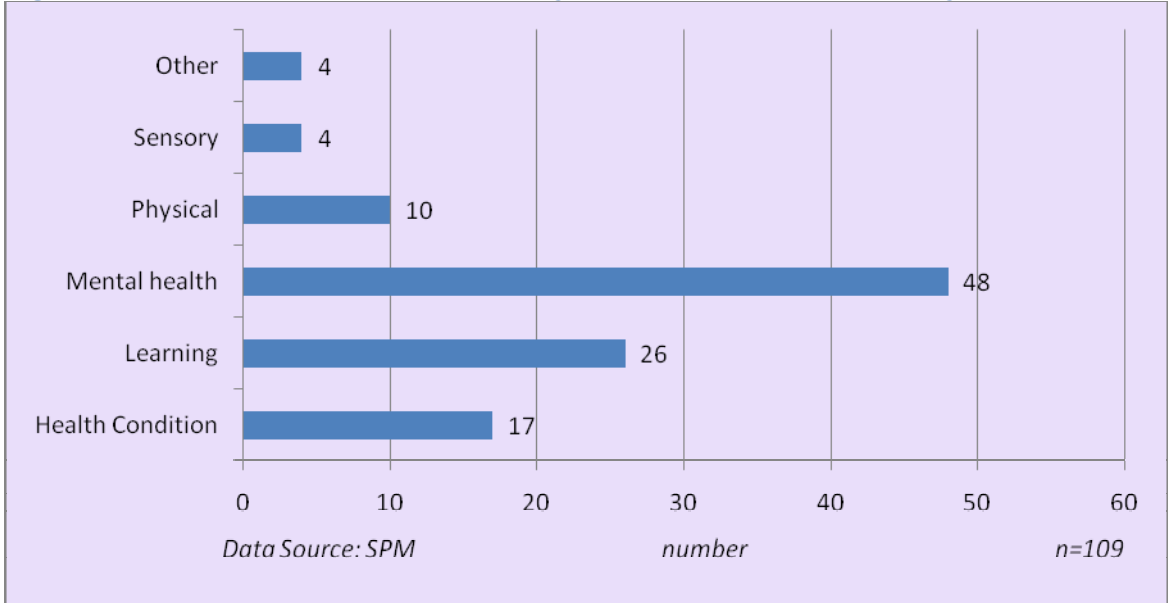
Table 13: Ethnicity of Referred Clients

	BME Number (%)	White Number (%)
SAFE Place Merseyside Sept 2008-Dec 2010 (n=487)	25 (4.8)	501 (95.2)
Client's from Liverpool PCT	19 (8.9%)	194 (91.1%)
Liverpool Population	31,055 (8.3%)	343,519 (91.7)

Source: SPM

The ethnicity of referred clients to SPM resident in Liverpool PCT are not significantly different to their proportion in the Liverpool population as estimated in mid-2007 by ONS. ($\chi^2=0.110921$, $p=0.7$).

Figure 7: Number of SAFE Place Merseyside Clients with a disability 2008-2010

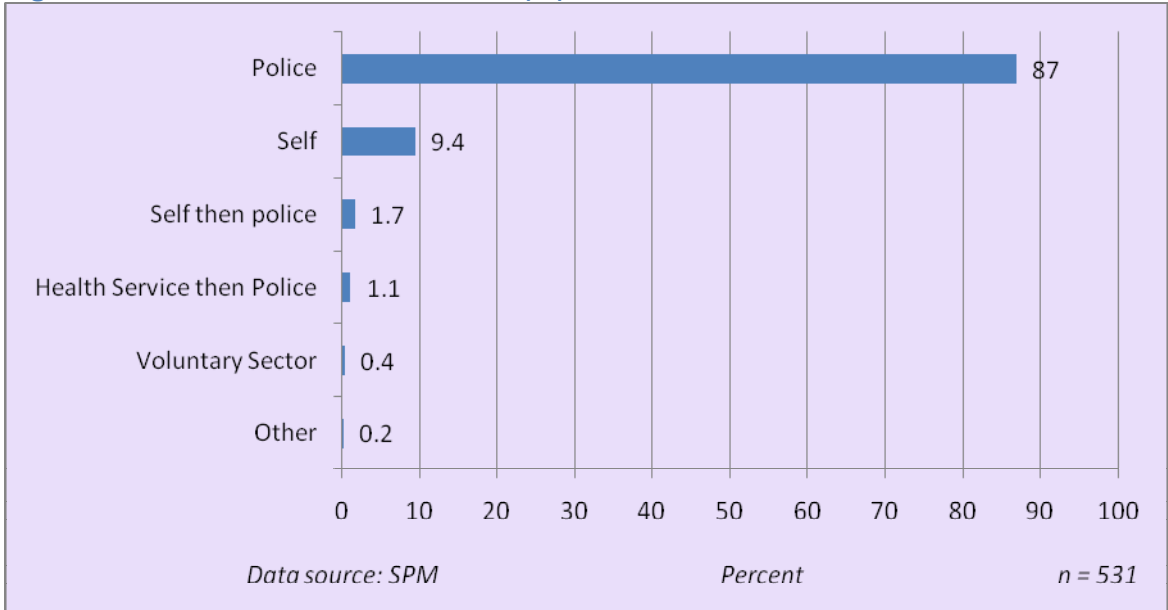


Out of 531 clients giving an answer to this question 109 (20.5%) said they had a disability and 422 (79.5%) declared they had none. Of those answering that they had a disability, the highest proportion 48 (44%) had a mental health condition, although this only represented 9% of the whole population.

Only 2 clients were reported as having no understanding of English and 4 had some difficulty. SPM can provide interpreting services for clients with no English and they can also accommodate clients who are deaf.

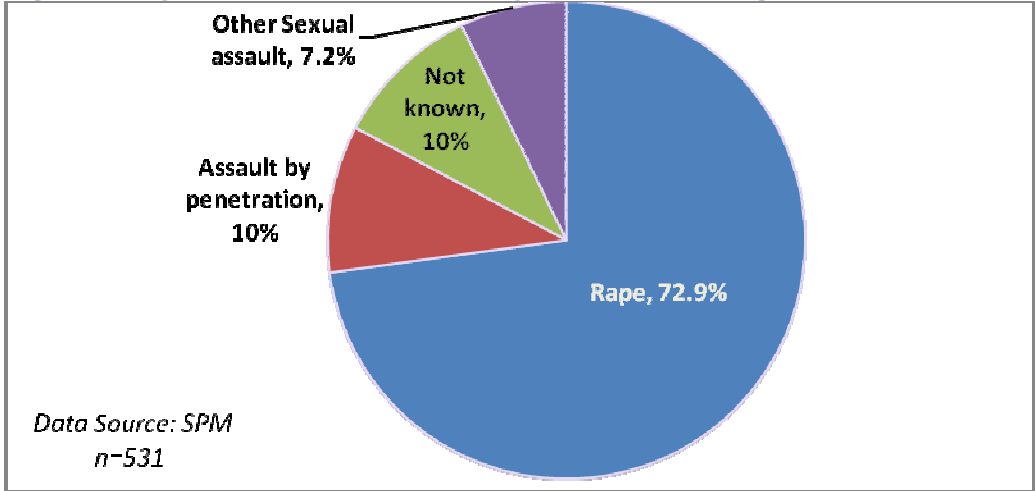
Only 4 clients reported being bisexual and 3 homosexual. However, there were 422 cases where sexual orientation was not disclosed.

Figure 8: Source of Referrals to SPM (%) 2008-2010



The majority of referrals to SPM were known to the police. Merseyside police made the most referrals (462, 87%). Nine self referrals and 6 referrals from the Health Service were later referred to the police making a total of 477 that were known to the police.

Figure 9: Type of offence reported by clients attending SPM -2008-2010



The majority of offences (387, 72.9%) reported by SPM clients were for rape. For 13.4% of clients (71) it was suspected that a substance assisted a sexual assault.

Table 14: Forensic Examination by sexual offence 2008-2010

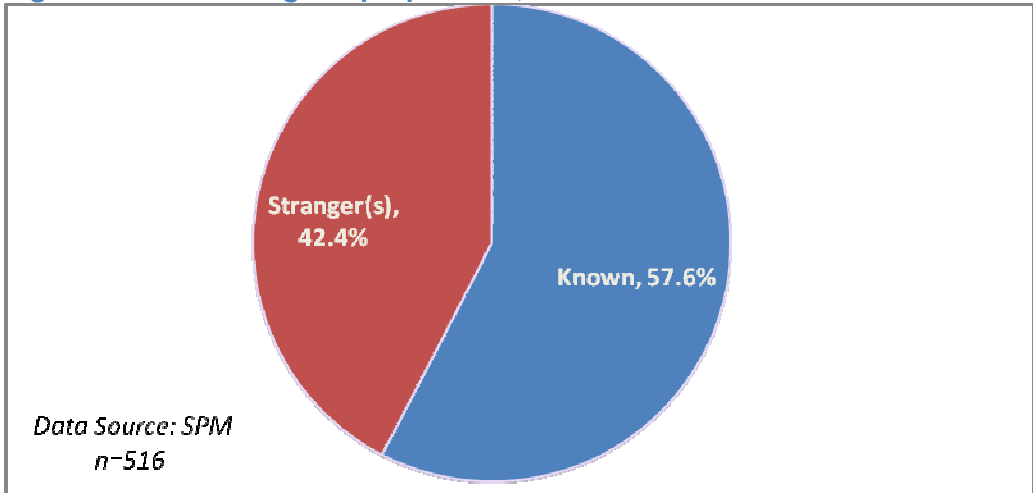
Sexual Offence	Forensic Examination					Total
	Forensic anonymous police referral	Forensic examination with police involvement	Forensic with no police involvement	No forensic examination	unreported	
Assault by penetration	1 (1.9)	50 (94.3)	2 (3.8)	0	0	53 (100)
Other Sexual Assault	0	29 (76.3)	1 (2.6)	8 (21.1)	0	38 (100)
Rape	1 (0.3)	329 (85)	13 (3.4)	42 (10.9)	2 (0.6)	387 (100)
Not specified/unknown	0	43 (81.1)	6 (11.8)	4 (7.5)	0	53 (100)
Total	2 (0.4)	451 (84.9)	22 (4.1)	54 (10.2)	2 (0.4)	531 (100)

Source: SPM

Eighty-five percent of SPM clients had a forensic examination with police involvement, therefore going through the crown prosecution service (CPS). Statistically significantly more victims of sexual assault by penetration had a forensic examination when compared to other clients. ($\chi^2=10.785527$, $df=2$, $p=0.005$) Of clients having a forensic examination, only 2 did not want to press charges but were happy for the police to use evidence from the forensic examination and 22 wanted no police involvement. A further 54 clients had no forensic examination.

Two sexual offences were related to trafficking, 15 were related to sex work and 1 was related to both.

Figure 10: Knowledge of perpetrator, SPM clients – 2008-2010



In 57.6% (297) of cases the perpetrator was known to the victim and in 41.2% of cases (219) they were reported as being a stranger. In 83 cases (15.6%) the perpetrator was a partner or ex-partner. In 11 cases (2.1%) the sexual offence took

place in the home shared by the victim and the offender and in 127 cases (23.9%) it was the victims' own home.

Table 15: Medication provided to SPM clients during 2008-2010 – number (%)

	Prophylaxis for STIs (e.g. Hepatitis B)	Prophylaxis against HIV (PEPSE)	Emergency Contraception
Not relevant	275 (51.8)	340 (64)	277 (52.2)
Offered at SPM – not taken up	15 (2.8)	24 (4.5)	31 (5.8)
Offered at SPM – taken up	116 (21.8)	87 (16.4)	211 (39.7)
Referred	127 (23.9)	80 (15.1)	12 (2.3)
Total	531 (100)	531 (100)	531 (100)

Source: SPM

Supplying Post Exposure Prophylaxis can reduce the risk of an infection developing and the need for GUM services. In over half of cases, the above services were not required. However, when they were, in most cases they were offered at SPM.

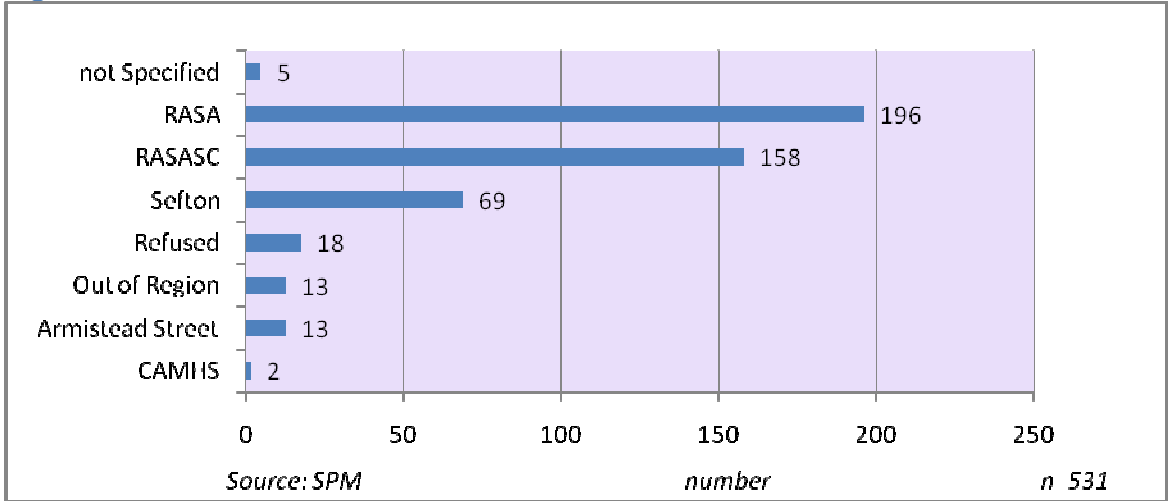
Table 16: Referral to other services 2008-2010 – number (%)

	Follow-up sexual health services	Advocacy / other non-therapeutic support	Paediatric Services
Not relevant	64 (12.1)	38 (7.2)	517 (97.4)
Offered at SPM – not taken up	17 (3.2)	76 (14.3)	3 (0.6)
Offered at SPM – taken up	115 (21.7)	242 (45.6)	5 (0.9)
Referred	335 (63.1)	175 (32.9)	6 (1.1)
Total	531 (100)	531 (100)	531 (100)

Source: SPM

Referrals were made for 63.1% of clients for follow-up sexual health services. Nearly a third of clients were referred for advocacy or other non-therapeutic support and only 6 were referred to paediatric services.

Figure 11: Referral to ISVA services SPM clients 2008-2010



Only 75, 14.1% of clients refused the support of an Independent Sexual Violence Advisor (ISVA). Two thirds of cases (66.7%) were referred to either RASA or RASASC (36.9% and 29.8% respectively). Sefton received 13% of referrals. Thirteen clients (2.5%) were receiving ISVA support from Armistread Street and 13 from out-of-the-region where their home PCT was situated.

Self-Referral Telephone enquiries to SPM: September 2009 – March 2011

The following information on self-referrals has been taken directly from a self-referral report supplied by SAFE Place Merseyside.⁵¹

Background

On the 22 September 2009, SAFE Place Merseyside (SPM) extended its services to self-referral clients in addition to those referred by the police. This enabled people who had experienced a sexual assault to access the services provided by SPM without prior police involvement, 24 hours a day, 365 days a year. This service extension was in accordance with a recommendation from the National Support Team (NST) for Response to Sexual Violence.

For self-referral clients, the initial contact with the centre is made when the caller telephones SPM. If the call is made during office hours, it is answered by a trained member of SPM staff. If the call is made outside of normal office hours, it is initially answered in a call centre in which the operators have been trained to handle and route calls on behalf of SPM. The operator takes the caller's name and contact number and informs the caller that a trained SPM crisis worker will return their call within thirty minutes. The crisis worker is contacted by the operator and returns the call to the client, recording the pertinent details on a report sheet that is subsequently sent to SPM via secure NHS email.

During the call, the crisis worker explains the services provided by SPM to the caller and identifies the help and assistance that is required.

A self-referral client may access one or more of the following services:

- Forensic Medical Examination with or without police involvement
- No Forensic Medical Examination but a report made to the police and access to sexual health services and other appropriate care
- Advice as to where sexual health services can be accessed other than SPM
- Signposting or referral to ISVA, Counselling and other appropriate Support Services
- Attendance at SPM to complete anonymous intelligence and access other support services

Performance Activity

The number of calls received between 22 September 2009 and 31 March 2011 totals 212. These are illustrated in Table 25 below. As anticipated, the number of self-

referral calls was small at first: in the seven months between September 2009 and March 2010, 50 calls were received. However, numbers have subsequently grown; between 1 April 2010 and 31 March 2011, 162 calls have been received.

Recent awareness-raising activity has resulted in a dramatic surge in self-referral calls. In particular, it is notable that the SPM website was launched on 28 February 2011. February had already seen more self-referral calls than any previous month - 17 calls compared with a monthly average of 9.6 for the previous months of 2010-11. During March 2011, 49 self-referral calls were received by SPM staff, an increase of more than 500% on the previous average.

The calls made from the clients in each of the 5 PCT areas are illustrated below. Each PCT shows a marked increase in the calls received during March 2011. (Please note that where 'Unknown' is recorded, this is due to the client declining to provide this information.)

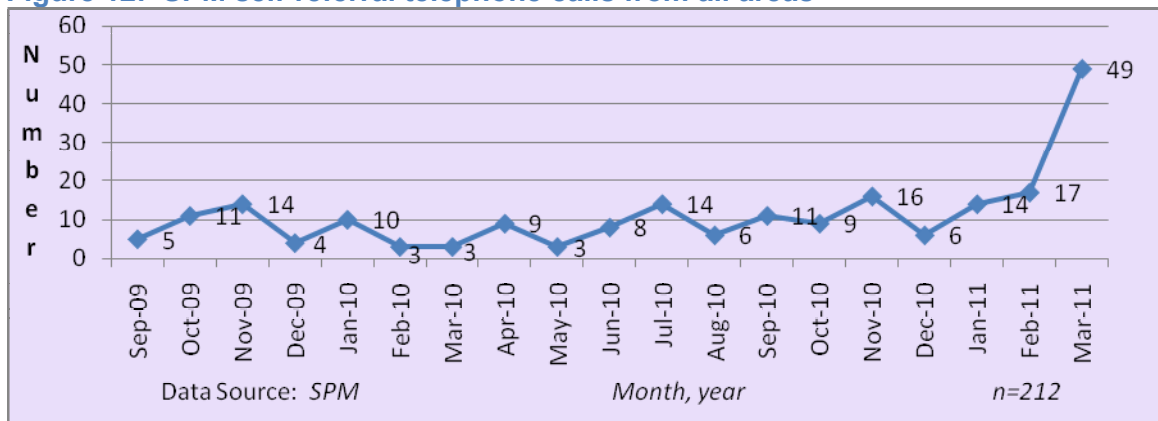
Table 17: Total telephone calls received by SPM: 22 September 2009 – 31 March 2011

	St Helens	Knowsley	Liverpool	Sefton	Wirral	Out of area	Cheshire	Unknown	Total
Sep-09	0	0	0	0	0	0	0	5	5
Oct-09	2	3	1	1	0	0	0	4	11
Nov-09	2	3	2	1	0	0	0	6	14
Dec-09	0	2	1	1	0	0	0	0	4
Jan-10	1	4	1	1	3	0	0	0	10
Feb-10	0	1	1	1	0	0	0	0	3
Mar-10	0	2	0	1	0	0	0	0	3
Apr-10	4	0	1	0	3	1	0	0	9
May-10	0	1	1	0	1	0	0	0	3
Jun-10	0	1	5	0	0	0	2	0	8
Jul-10	4	2	1	4	3	0	0	0	14
Aug-10	0	3	1	1	0	1	0	0	6
Sep-10	0	2	3	3	3	0	0	0	11
Oct-10	0	4	2	3	0	0	0	0	9
Nov-10	2	4	8	2	0	0	0	0	16
Dec-10	0	1	3	1	1	0	0	0	6
Jan-11	0	3	5	2	4	0	0	0	14
Feb-11	1	1	4	1	10	0	0	0	17
Mar-11	10	10	11	8	9	0	0	1	49
Total	26	47	51	31	37	2	2	16	212

Data Source: SPM

Most telephone calls are received from Liverpool (51, 24.1%) and Knowsley (47, 22.2%), where they receive a number of homeless clients.

Figure 12: SPM self-referral telephone calls from all areas



- Of the 212 self referral calls received in the 19 months covered in the data, the average number of calls per month was 7 in 2009-10 and 9.6 for the first eleven months of 2010-11.
- Over 23% of the 212 calls were received during March 2011, following the launch of the dedicated website. (Prior to the website, the annual number of calls was 123.)
- If the rate of calls remains at 49 per month, there should be in excess of 580 self-referral calls per year.

The following graphs show the trends in each PCT during the 19 months that the self-referral service has been available.

Figure 13: SPM self-referral telephone calls from St Helens



Figure 14: SPM self-referral telephone calls from Knowsley



Figure 15: SPM self-referral telephone calls from Liverpool

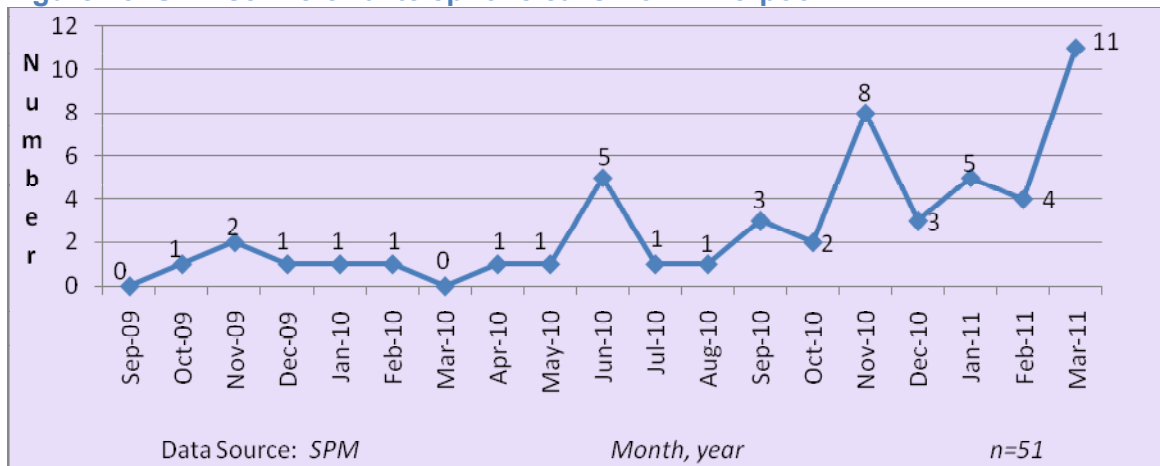


Figure 16: SPM self-referral telephone calls from Sefton

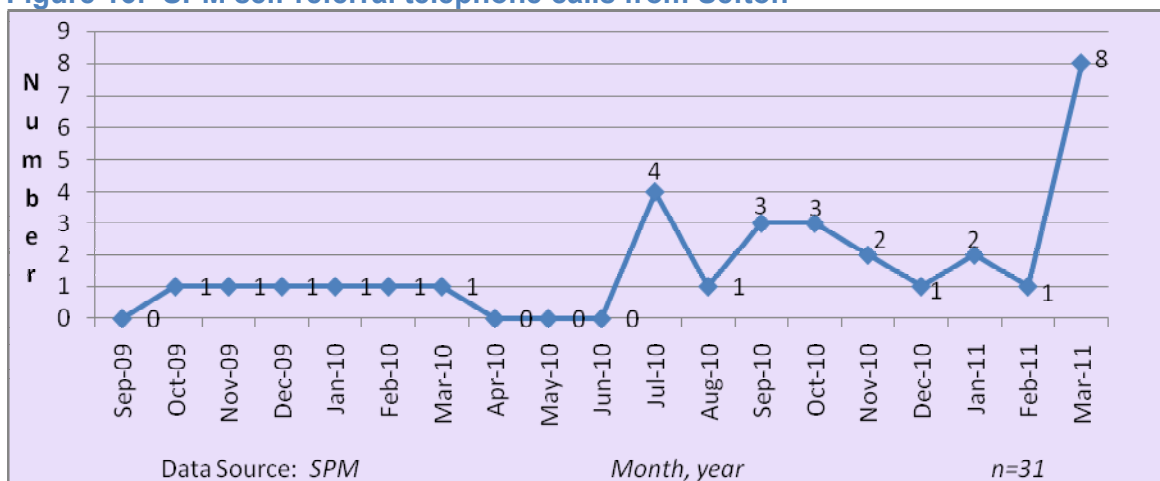


Figure 17: SPM self-referral telephone calls from Wirral

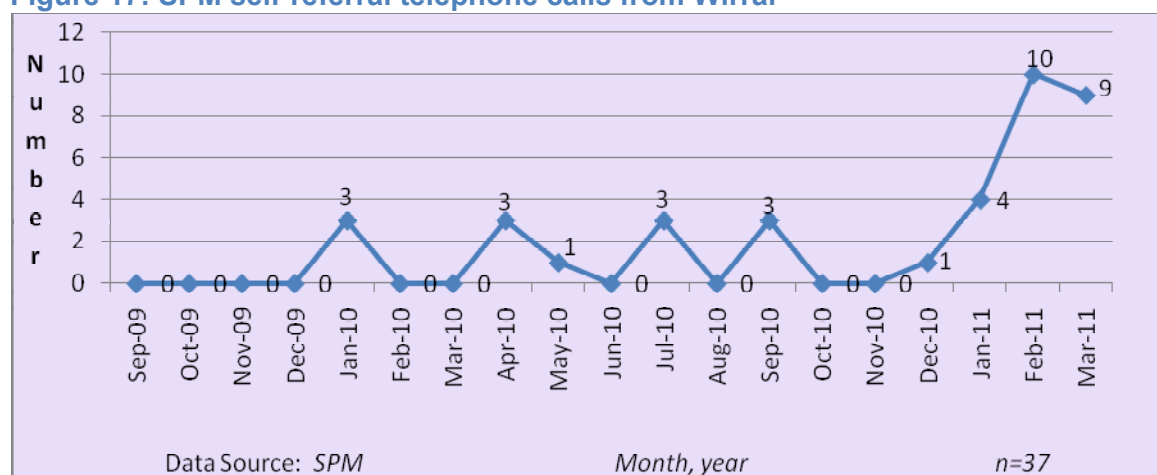


Table 18: Self Referral Calls to SPM: 1st April 2011 – 30 June 2011

PCT	April 2011	May 2011	June 2011	Running Total
Knowsley	12	11	7	30
Liverpool	12	14	14	40
St Helens	4	7	1	12
Sefton	6	9	12	27
Wirral	8	9	1	18
Undisclosed	0	0	4	4
Out of Region	2	1	1	4
Totals	44	51	40	135

From their peak in March at 49 self-referrals, calls have continued around this relatively high level during the first quarter of the financial year – April-June 2011. These self-referrals have resulted in some excellent outcomes as in medical examinations, reporting to the police, completion of anonymous intelligence, referral to GUM Clinics and signposting to counselling.

Benefits of offering a Self-referral service

It is accepted that many people who have been subjected to a sexual assault do not feel able to report it to the police in the first instance. Despite the advances made in police practice, this is not always reflected in an individual's expectations, especially when they are traumatised. By calling SPM directly, clients are helped to understand the processes involved in reporting a sexual assault and are informed of the actions that can be taken to minimise the problems that can occur as a result of a sexual assault. The service provides a one stop shop for arranging examinations and other appropriate support whilst providing clients with the confidence to access the help and support needed to enable them to minimise the physical and mental impact of a sexual assault. Wherever possible, SPM staff encourage self-referring clients to go on to report their assault to the police, whilst recognising that the client's choice is final and in some cases they will continue to refuse police involvement. In all cases, clients are assisted to access appropriate support services, in keeping with the SPM mission to improve recovery and long-term prognosis for survivors of sexual assault.

Financial Implications of offering a self referral service

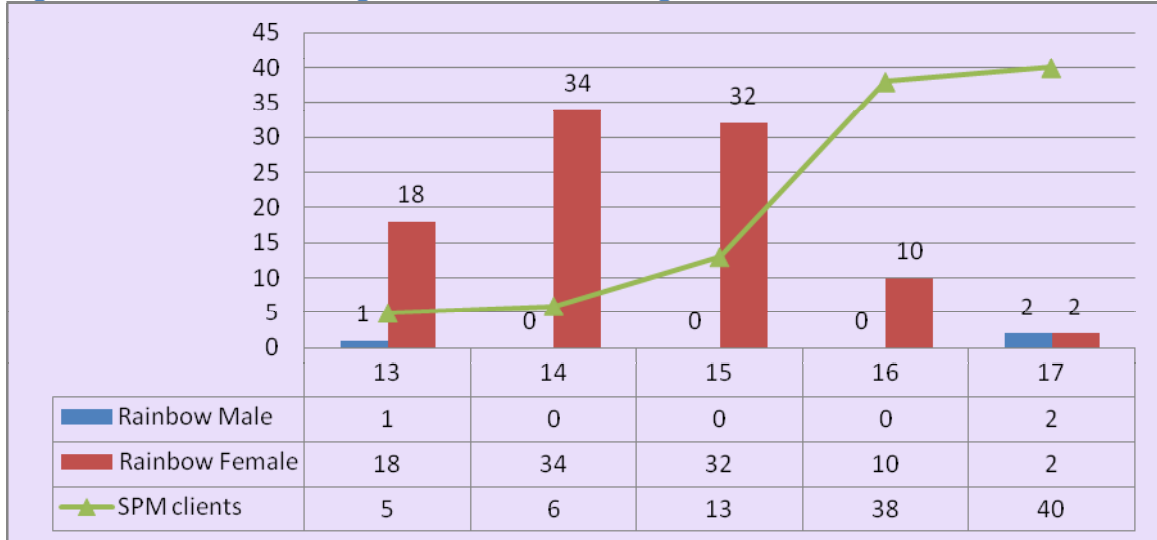
The cost of providing SPM services for self-referral clients is very difficult to determine in a meaningful way. The length of time spent with the client depends on the individual's needs and level of interaction. Given the nature of the motivation to make a self-referral call, the length of time can vary hugely. Some calls take less than ten minutes; others last well over an hour and can start a process that requires a number of additional calls to be made (for example, to an FME, the Unity Team, to a hospital or a partner agency for support services).

Problems with data from SAFE Place Merseyside

Due to administrative systems errors during 2008-2009, there were a number of errors that were initially recorded on their database for day of attendance and a relatively large number of unspecified items. A few items were misclassified. Since then their new data analyst has checked all items and the data is now recorded appropriately.

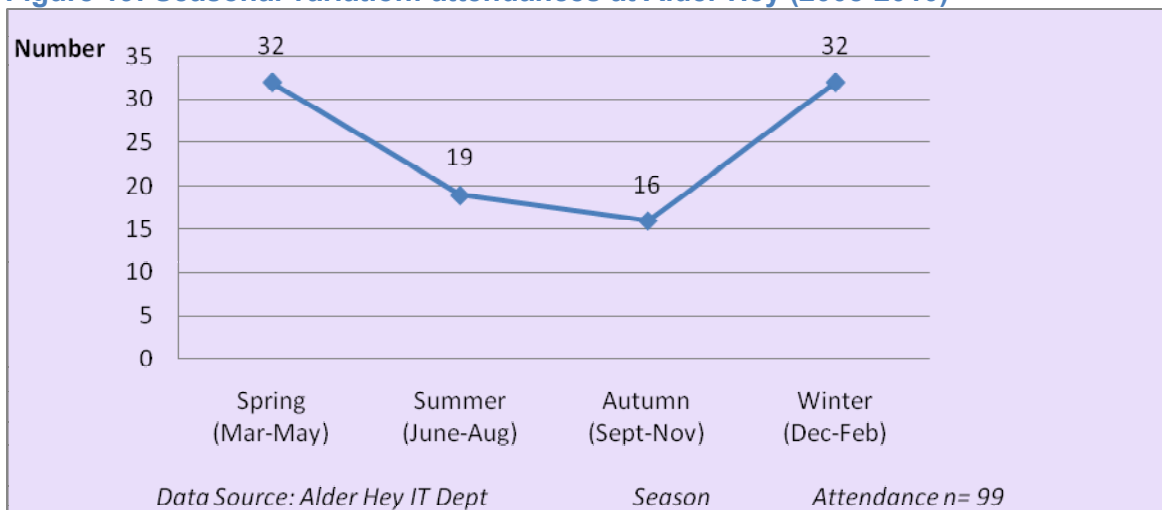
Activity Data from Alder Hey Rainbow Centre

Figure 18: Gender and Age of victims attending the Rainbow Centre, 2008-2010



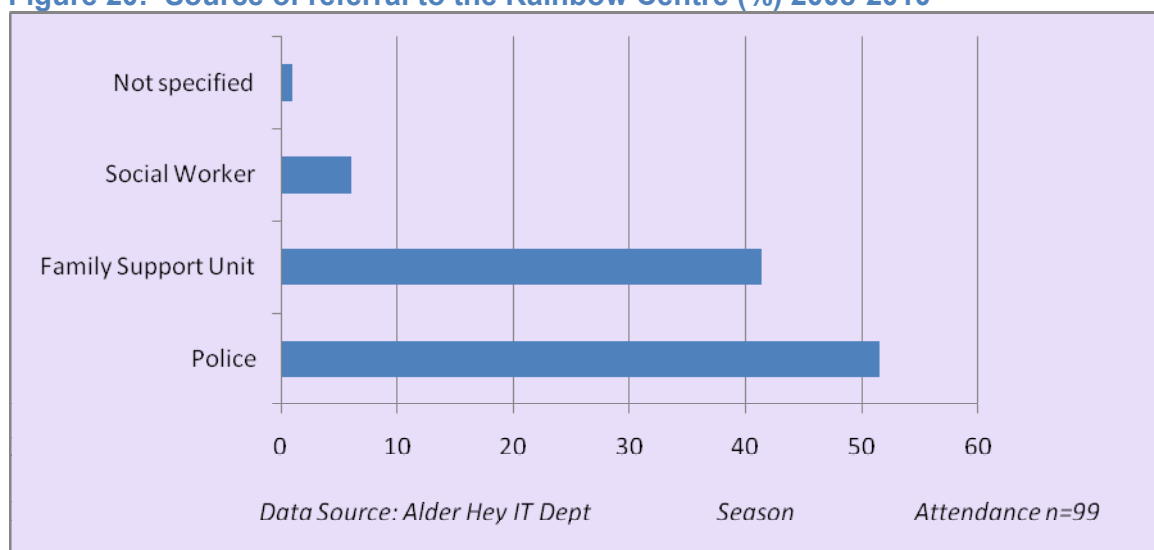
The above graph shows the age and sex of clients attending the Rainbow Centre during 2008-2010. There were 99 clients of which 97% were female between the ages of 13-17. From the age of 16 the majority of clients are seen at SAFE Place Merseyside. Most children under 16 are seen at the Rainbow Centre. Within this 13-17 age-group, in 2008 the Rainbow Centre saw 38 clients, 28 clients were seen in 2009 and in 2010 33 clients. Over these 3 years they saw an average of 3 clients per month aged 13-17.

Figure 19: Seasonal variation: attendances at Alder Hey (2008-2010)



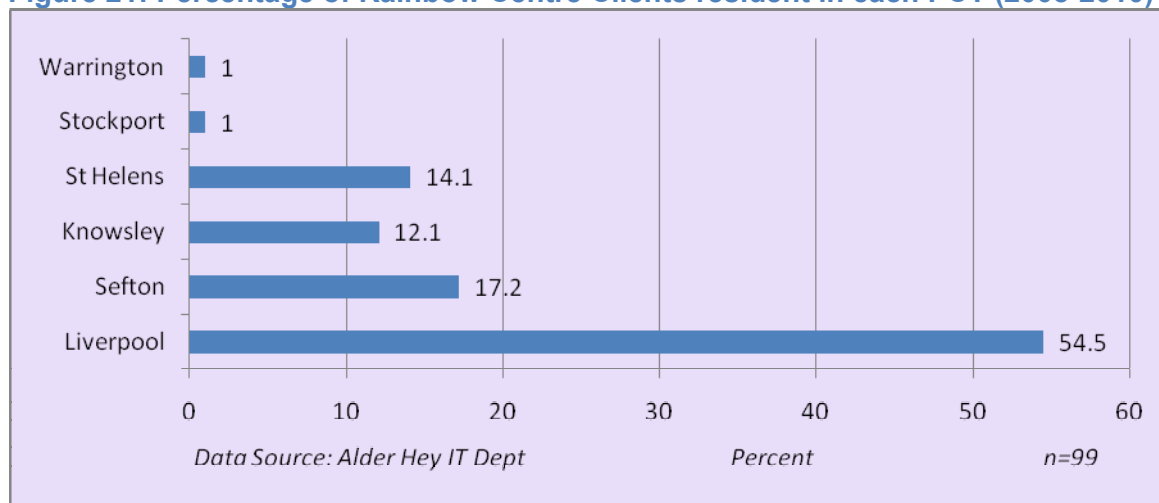
Most attendances were seen during the winter and spring months during 2008-2010 for this age-group.

Figure 20: Source of referral to the Rainbow Centre (%) 2008-2010



Family Support Unit (FSU) now known as FCIU Family Investigation crime Unit is the police unit which deals with family safeguarding issues in hours. Out of hours the cases are referred by the police. Nearly 93% of clients are referred from the police or FSU, with the majority being referred by the police out of hours. There is no ISVA service for adolescents to be referred on to from the Rainbow Centre.

Figure 21: Percentage of Rainbow Centre Clients resident in each PCT (2008-2010)

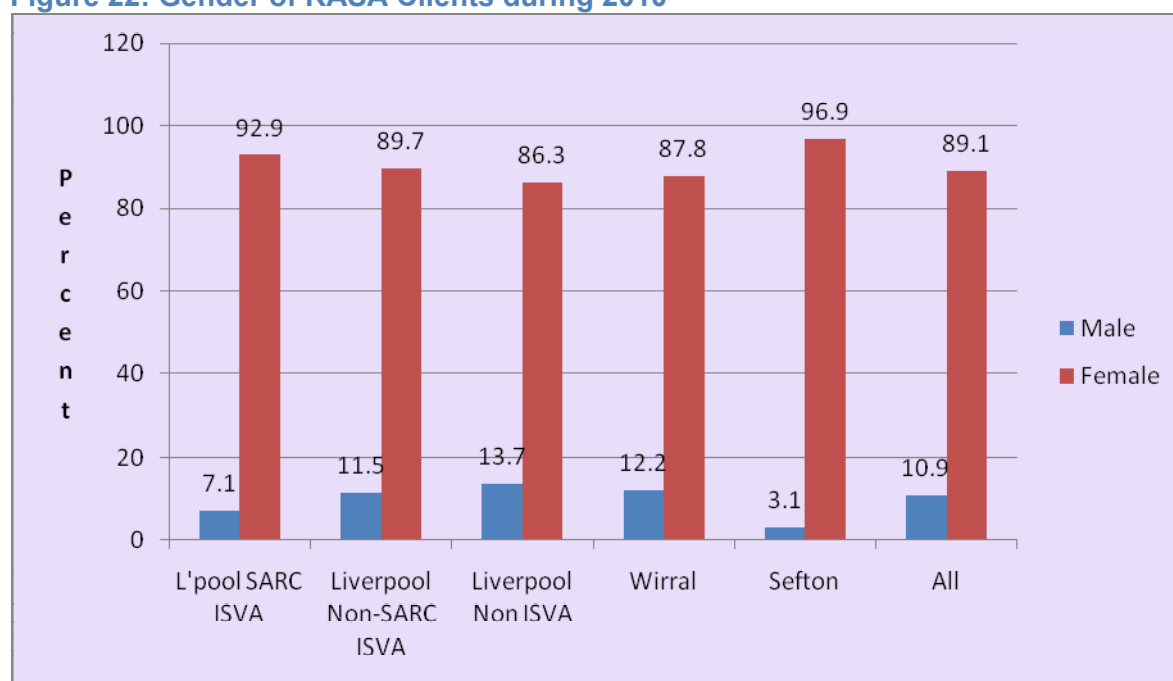


Most clients, over half, were from Liverpool. No clients were received from the Wirral at this time. Until April 2011 the Rainbow Centre at Alder Hey was not commissioned to provide care for children from Wirral who have experienced sexual assault.

Ethnicity was available for 81 Rainbow Centre clients (81.8%). Of these clients 79 (97.5%) were white British and 2 (2.5%) were BME: 1 Asian from Liverpool and 1 black British from Stockport.

RASA Activity data – year ending 2010

Figure 22: Gender of RASA Clients during 2010



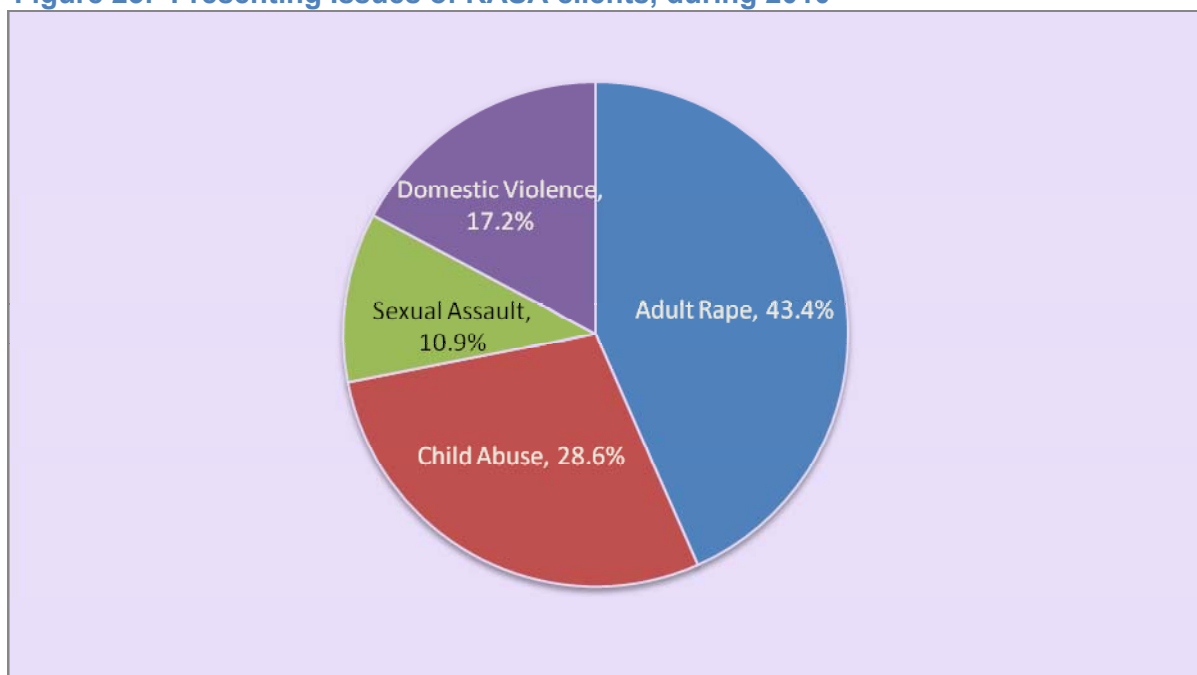
RASA Service	Period covered	Total Clients	Male	Female
Liverpool SARC ISVA	April – Dec 2010	99	7 (7.1)	92 (92.9)
Liverpool Non-SARC ISVA	April – Dec 2010	58	6 (11.5)	52 (89.7)
Liverpool Non ISVA	Jan – Dec 2110	365	50 (13.7)	315 (86.3)
Wirral	Jan – Dec 2110	312	38 (12.2)	274 (87.8)
Sefton	Jan – Dec 2110	161	5 3.1(3.1)	156 (96.9)
Total		995	108 (10.9)	887 (89.1)

Data Source: RASA

The above figure and table shows the percentage (and numbers in the table) of clients who were male and female in each of RASAs services during 2010 without any duplication. There were some clients from Liverpool who also received counselling whilst in the ISVA service.

RASA had 995 clients during 2010 of which 10.9% were male and 89.1% were female.

Figure 23: Presenting Issues of RASA clients, during 2010



RASA Service	Presenting Issues – number (%)				
	Adult Rape	Child Abuse	Sexual Assault	Domestic Violence	Total
Liverpool SARC ISVA	77 (67)	9 (7.8)	17 (14.8)	12 (10.4)	115 (100)
Liverpool Non-SARC ISVA	28 (35.4)	24 (30.4)	17 (21.5)	10 (12.7)	79 (100)
Liverpool Non ISVA	253 (43.6)	198 (34.1)	71 (12.2)	58 (10)	580 (100)
Wirral	167 (37.4)	120 (26.9)	43 (9.6)	116 (26)	446 (100)
Sefton	99 (45.2)	60 (27.4)	9 (4.1)	51 (23.3)	219 (100)
Total	624 (43.4)	411 (28.6)	157 (10.9)	247 (17.2)	1439 (100)

Data Source: RASA

Many of RASA clients presented with multiple issues. Adult rape was the most often reported presenting issue followed by recent or historic child abuse.

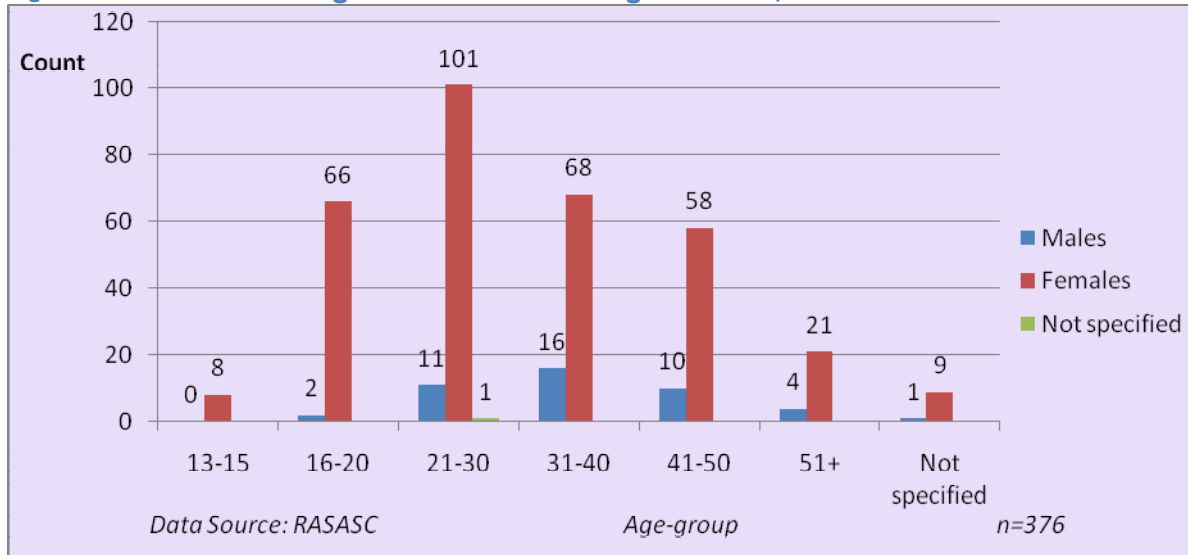
Problems with the data from RASA

Data is limited as the organisation does not have funds for a data analyst. Thus to collate data is very time consuming by hand and they only keep records on computer for one year. Therefore the ages of clients, the numbers from each referral agency or numbers where clients were referred was not available in all instances.

Prior to 1 April 2010, RASA shared the Liverpool City Centre with RASASC and therefore was not commissioned to serve all Liverpool ISVA clients as they only looked after North Liverpool. Therefore they were unable to supply figures for 1 January – 31 March 2010 for the whole of Liverpool. Referrals into the service could not be recorded here as the figures did not always match the figures in the above table as there were some clients who were recorded twice. For instance, in a Liverpool ISVA service and the Liverpool Non ISVA service at the same time.

Data from Rape and Sexual Abuse Support Centre (RASASC)

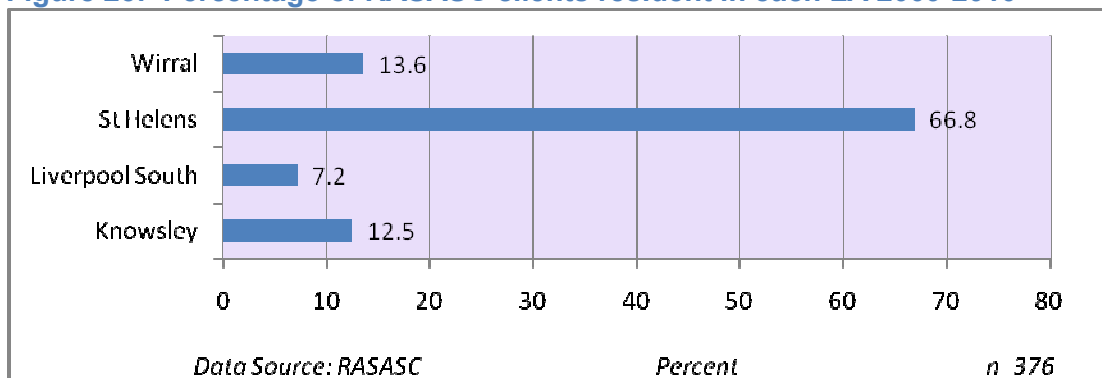
Figure 24: Gender and Age of clients attending RASASC, 2009-2010



The age-range of RASASC’s Merseyside clients during a two year period range from 13-72. Figure 20 shows, the number of clients seen peaks for the 21-30 age-group with 30.1% in this age-group, although most (36.4%) male clients were between 31-40. Only 6.7% of clients were in the oldest age-range with only 4 people over 60. For 10 clients their age is not specified. Of 375 clients where the gender is specified, 331 (88%) were female and 44 (11.7%) were male.

Over a 22 month period from March 2009-December 2010 (as only one person was seen in January and none in February 2009) 375 people were seen making an average of 17 new clients per month from Merseyside.

Figure 25: Percentage of RASASC clients resident in each LA 2009-2010



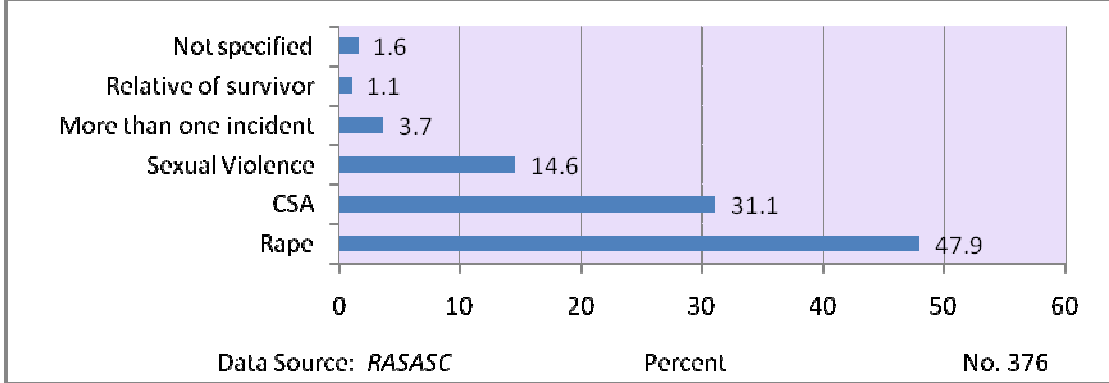
Two-thirds of RASASC clients (251) were from St Helens. They have only received a contract to receive clients from the Wirral since 23 February 2010, but already they have received 51 clients which represent 13.6% of their clients from Merseyside. Forty-seven (12.5%) of Merseyside clients come from Knowsley and only 27 (7.2%)

from South Liverpool. However, RASASC only received clients from 8th April 2009 – 25th November 2010 as the contract for the whole of Liverpool passed to RASA.

Ethnicity was only available for 55.1% (206) of RASASC clients. Of these 97.6% (201) were white and 5 were from black minority ethnic groups.

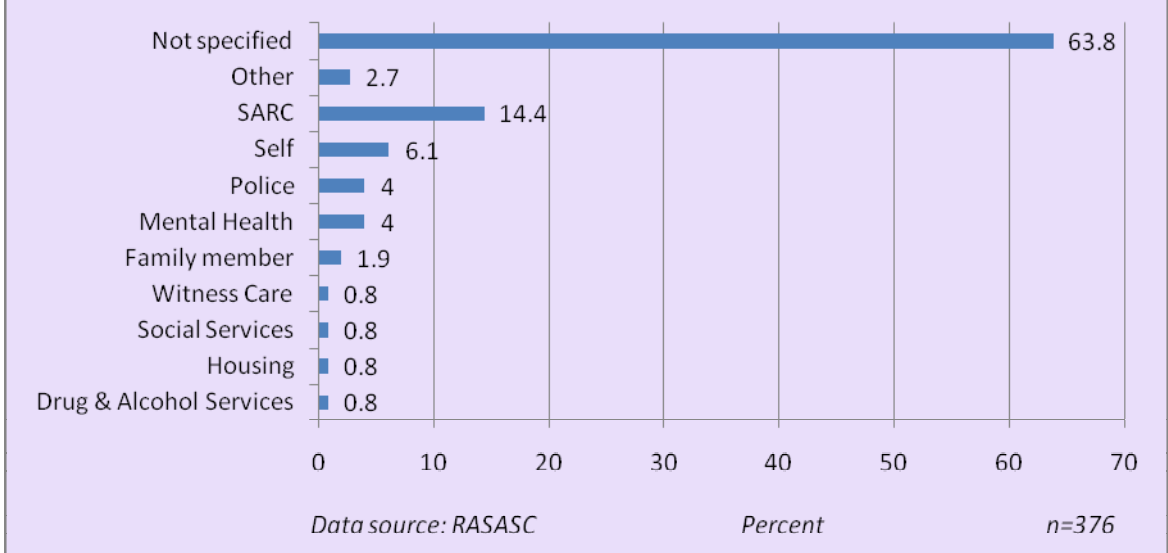
Employment status was recorded for 48.8% (176) of clients. Of these clients 79 were unemployed, 49 were employed, 25 were students, 4 were home-makers and 1 was retired.

Figure 26: Presenting Incidents of RASASC Clients 2009-2010



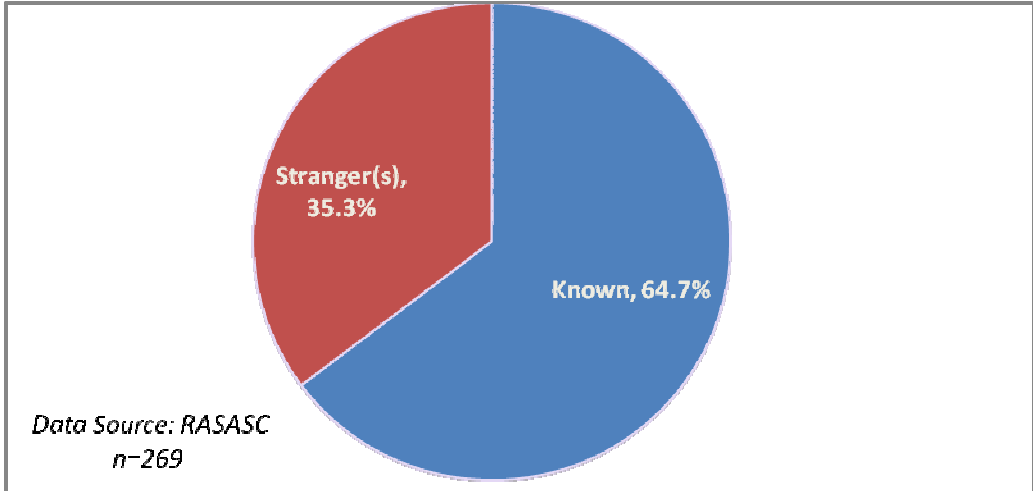
Rape consisted of nearly a half of all presenting cases to RASASC during 2009-2010, with nearly a third being for child sexual abuse (CSA).

Figure 27: Source of Referral to RASASC (%) 2009-10



In the past it was not a requirement to record source of referral therefore, the majority of 240 (63.8%) of referrals to RASASC is unknown. Of the remainder 54 (14.4%) were referred by SARC and 23 (6.1%) were referred. However, RASASC have confirmed that the majority of their referrals are self-referrals.

Figure 28: RASASC clients' relationship to perpetrator, 2009-10

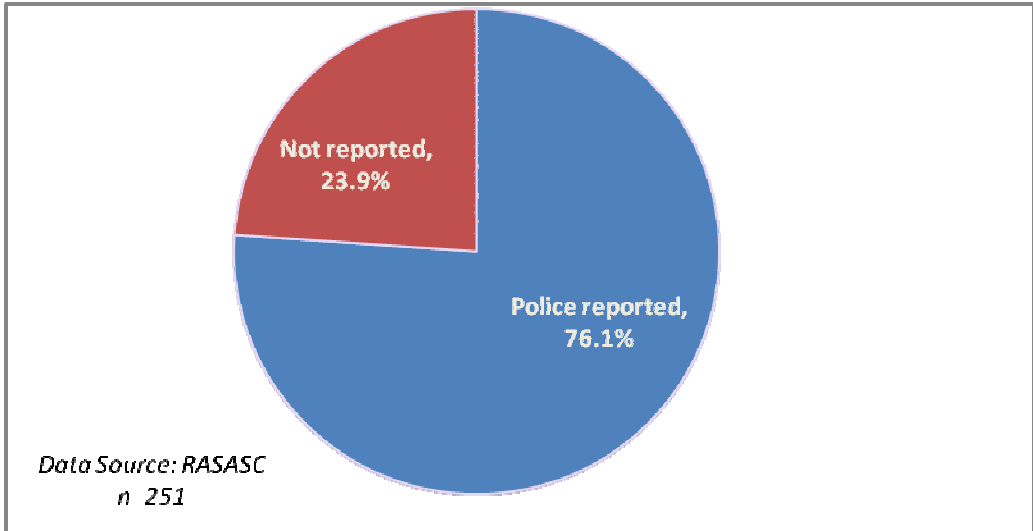


Most clients (174) knew the perpetrator. In 75 cases (19.9%) it was a known relative and for 28 (7.4%) it was a partner or ex-partner.

Out of 149 cases where the location of the offence is reported, 64 incidents (43.5%) took place in either the family or victim's home. In 20 cases (13.4%) the incident took place in the perpetrator's home.

Eight cases (2%) were reported to be alcohol assisted and 4 cases (1%) were known to be drug assisted.

Figure 29: Whether the RASASC incidents were reported to the police, 2009-10



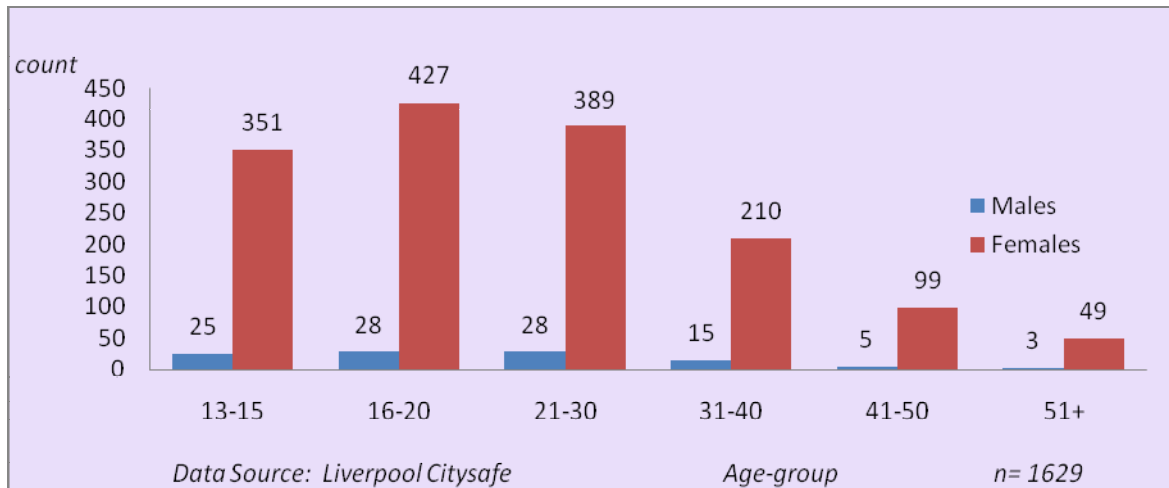
In the majority of 191 cases the offence was reported to the police.

Problems with RASASC data

For a large percentage of clients it is not specified where referrals were from. Data is only available for two years, 2009-2010. Prior to that data was not recorded on a computer spreadsheet, so would have required hand counting.

Police Reported offences on Merseyside

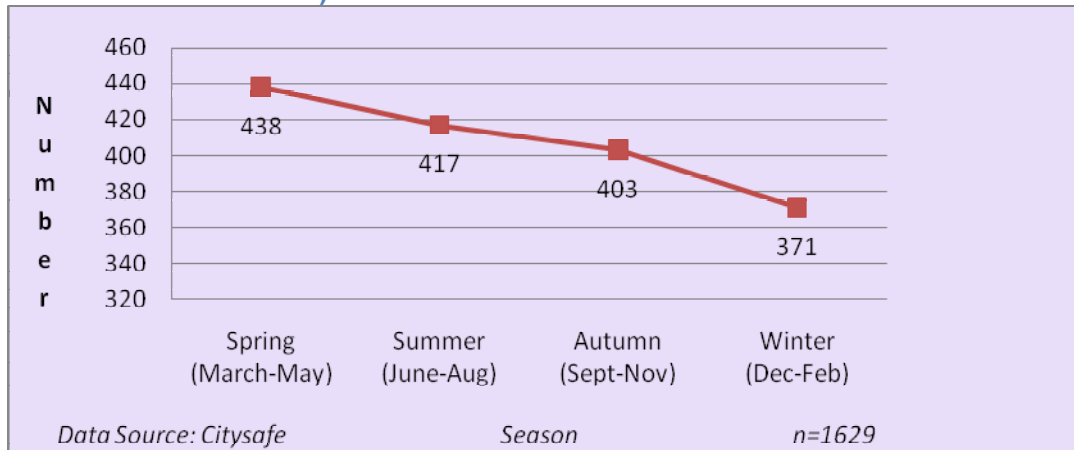
Figure 30: Gender and age of victims from Merseyside police data, 2008-2010



From January 2008 until the end of December 2010 1629 sexual offences were reported to the police of which 1525 (93.6%) were from female victims leaving only 104 (6.4%) from males. The ages shown are the age of the victim at the time of the sexual offence. The most recorded offences came from the 16-20 age group totalling 455 making 28% of recorded offences. After this peak the reported offences reduce for each subsequent age-group. Only 6.4% of offences were reported by victims in age-group 41-50, and just 3.2% for the over 50s.

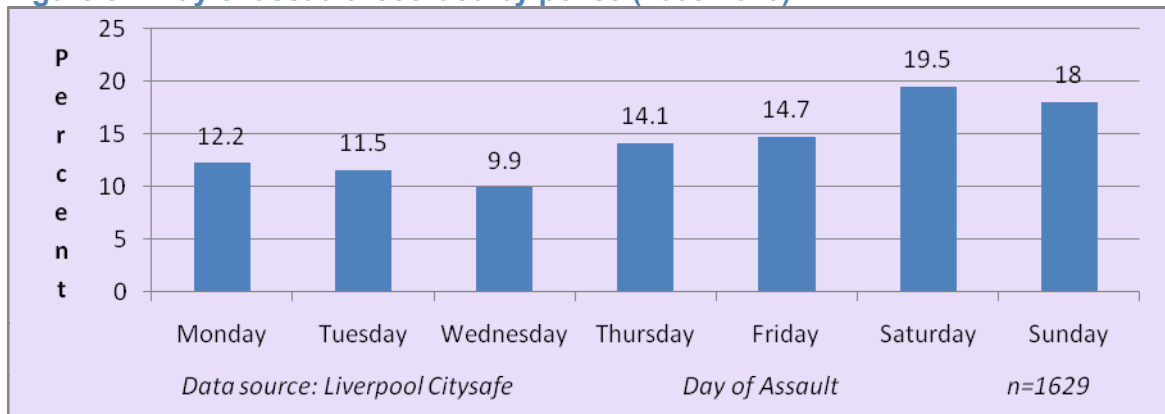
Over the three year period from January 2008 until December 2010, 1,629 sexual offences were reported on Merseyside. This equates to 543 per year reported from victims who were 13 and over at the time of the offence.

Figure 31: Seasonal variation in offences by earliest date of crime on police data (Jan 2008 – December 2010)



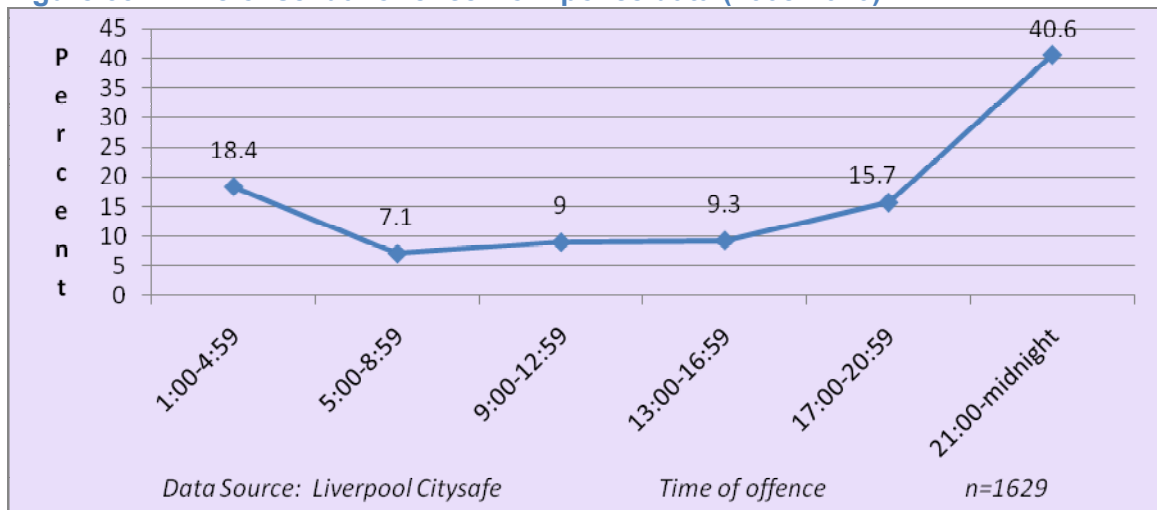
Over half (52.5%) of offences occurred during the spring and summer months.

Figure 32: Day of assault recorded by police (2008-2010)



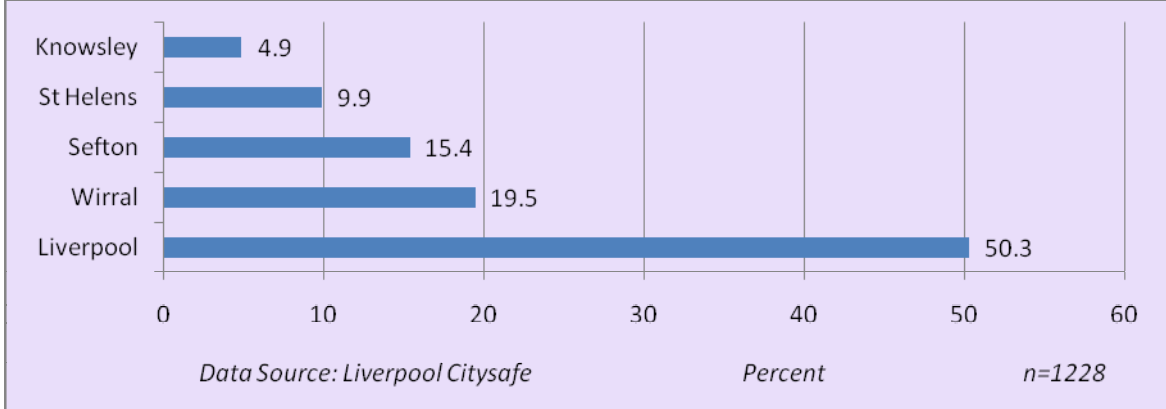
Most offences occurred at the weekend, (611, 37.5%). This shows a possible link with the night-time economy.

Figure 33: Time of sexual offence from police data (2008-2010)



The majority of sexual offences (299, 58%) occurred between the hours 9pm and 5am. This again shows a link with the night-time economy.

Figure 34: Percentage of police reported offences in each Local Authority 2008-2010



Half of all reported sexual offences in Merseyside are within Liverpool, with a fifth from Wirral. Knowsley has the least reported sexual offences, followed by St. Helens and Sefton.

Table 19: Wards with the highest recorded sexual offences on Merseyside during 2008-2010 by deprivation

Ward	Local Authority	Sexual Offences	Crude rate per 1,000 population 13+	IMD Ward Scores (2010)*
Central	Liverpool	136	10.15	29.3
Riverside	Liverpool	83	6.6	53.6
Birkenhead & Tranmere	Wirral	62	5.36	61.9
Kensington & Fairfield	Liverpool	59	4.82	58.7
Dukes	Sefton	50	4.28	26.8
Tuebrook & Stoneycroft	Liverpool	43	3.22	55.4
Picton	Liverpool	42	2.86	53.1
Linacre	Sefton	41	4.0	55.7
Town Centre	St Helens	39	4.18	46.6
Princes Park	Liverpool	39	3.3	62.4
Bidston & St James	Wirral	38	3.28	62.9
Everton	Liverpool	36	3.06	71.8

Source: Liverpool Citysafe, ONS Mid-year population estimates 2009, Indices of Deprivation 2010

*The higher the score the more deprived the ward

For Table 19 and 20, population weighted IMD ward scores (or raw data so they could be calculated) were supplied by PCT public health intelligence teams. The wards and Local Authority refer to where sexual offences took place.

From the IMD ward scores for 2010 it shows that 10 out of 12 (83.3%) of wards with the highest recorded numbers of sexual offences are amongst the most deprived

areas. These include Bidston, Birkenhead and Tranmere which are situated in the most deprived dockland areas on the Wirral.

There is also a connection with the night-time economy as Central Liverpool, Dukes, (the 2 least deprived wards in the above table) Birkenhead, Linacre and St Helens Town Centre are areas that cater for the night-time economy with nightclubs and public houses. Riverside also includes the southern part of the Liverpool City Centre.

Table 20: Wards with the lowest recorded sexual offences on Merseyside during 2008-2010 by deprivation

Ward	Local Authority	Sexual Offences	IMD ward scores (2010)
Rainford	St Helens	1	17.9
Roby	Knowsley	1	14.1
Shevington	Knowsley	1	24.1
Birkdale	Sefton	2	13.1
Harington	Sefton	2	9.6
Manor	Sefton	2	28.5
Park	Knowsley	2	31.3
Page Moss	Knowsley	2	52.9
Greasby Frankby & Irby	Wirral	2	9.0
Molyneu	Sefton	3	15.0
Park	Sefton	3	12.2
Woolton	Liverpool	3	16.6
Heswall	Wirral	3	6.7
Cherryfield	Knowsley	3	39.6
Halewood North	Knowsley	3	13.2
Halewood South	Knowsley	3	34.1

Source: Liverpool Citysafe; Indices of Deprivation, 2007 & 2010

*The higher the score the more deprived the ward

Out of 16 wards, with a very low number of sexual offences recorded, 11 or nearly 69% were amongst the least deprived within Merseyside.

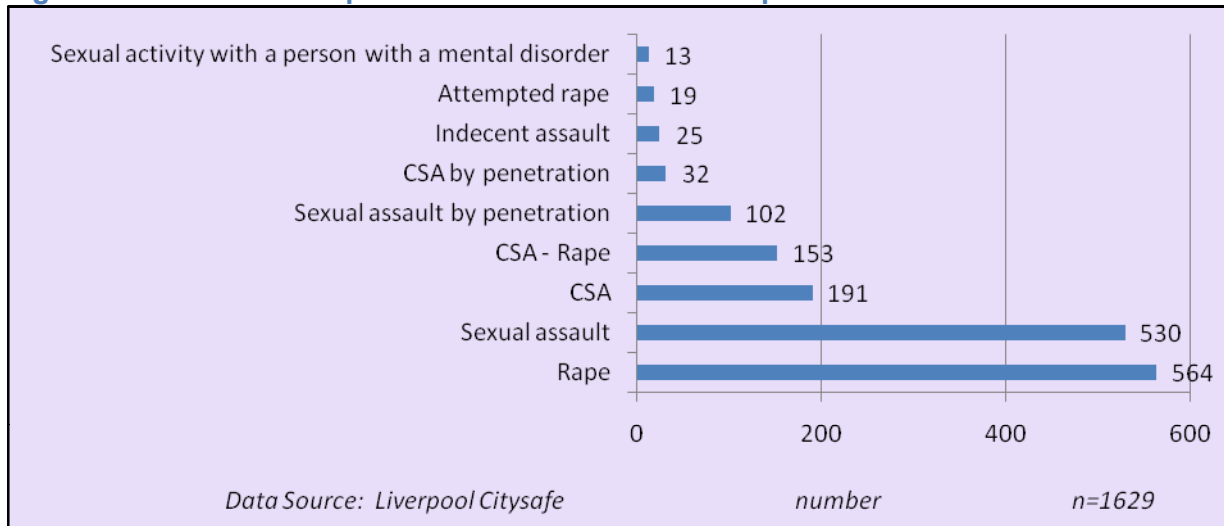
Table 21: Composition of the minority ethnic victims of sexual offences aged 13 and over 2008-2010 number (%)

Asian/ Asian British	Black/ Black British	Mixed	Chinese or Other Ethnic group	Total
9 (14.8%)	29 (47.5)	11 (18)	12 (19.7)	61 (100)

Source: Liverpool Citysafe

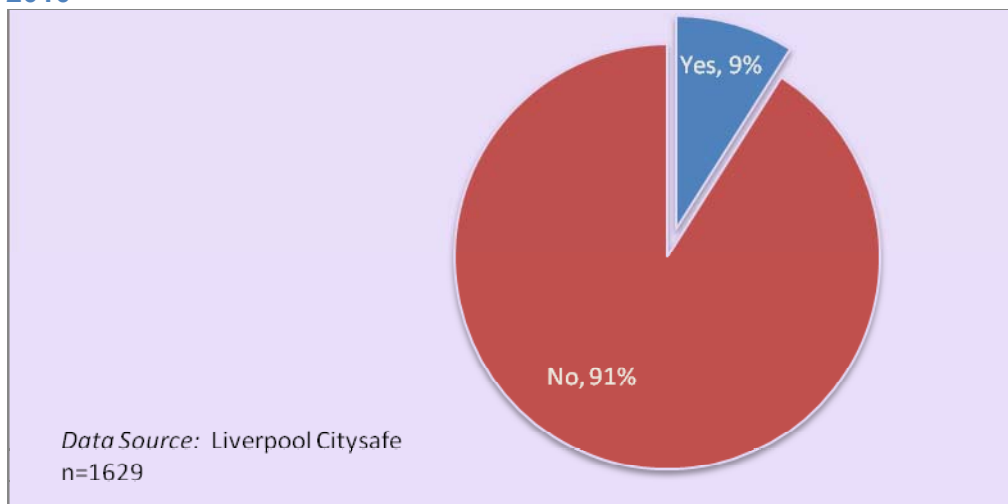
Data on ethnicity was available for 84.2% (1371) of victims reporting a sexual offence. Of the 61 victims recorded as Black and Minority Ethnic (BME) representing 4.4% of all victims between 2008 and 2010, nearly half (29, 47.5%) were black or black British.

Figure 35: Number of reported sexual offences to the police – 2008-2010



Child sexual abuse (CSA) is recorded for victims who were under 16 at the time of the offence. Over a third of reported sexual offences were for rape or attempted rape (573, 35.7%). Just under a third was for sexual assault (530, 32.5%) and taken together all CSA offences accounted for 23.1% (376) of reported sexual offences. Of the remaining offences, sexual assault by penetration accounted for 6.3%, indecent assault 1.5% and sexual activity with a person with a mental disorder 0.8% of all sexual offences reported during 2008-2010.

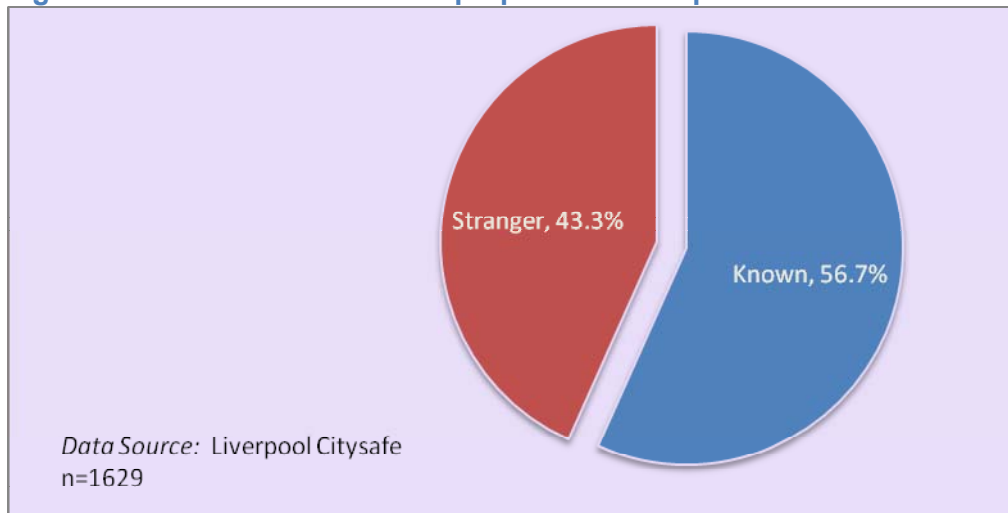
Figure 36: Sexual offences that are classed as domestic violence on police data 2008-2010



Domestic violence refers to “Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, [and can involve children] regardless of gender and sexuality”^{52 53}.

There were 147 (9%) reported sexual offences on Merseyside that were classed as domestic violence on the police data during 2008-2010. Of these 147 offences, 20 (13.6%) involved children between the ages of 13-15.

Figure 37: Whether victim knew perpetrator from police data



From the police data of reported sexual offences during 2008-2010, 924 (56.7%) victims knew their attacker.

Figure 38: Alcohol influenced sexual offences from police data

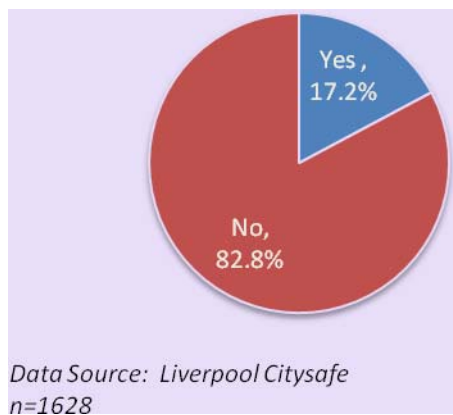
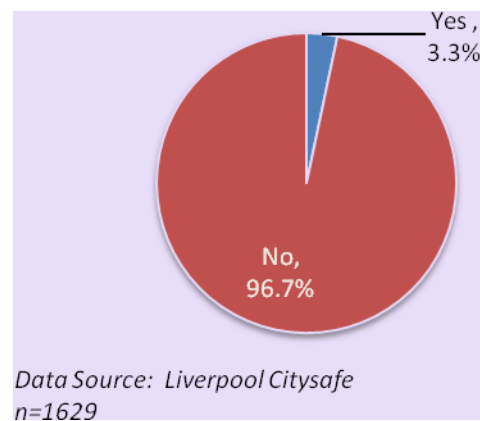


Figure 39: Drug influenced sexual offences from police data



From the crime notes it is indicated that 280 (17.2%) of reported sexual offences are related to alcohol intake, by the perpetrator or victim. Of these 280 victims 26.1% (73) were between the ages 16-20 and 31.8% (89) were in the age-group 21-30. Only 54 sexual offences during 2008-2010 were related to drug intake by either the victim or offender.

There were 93 (5.7%) sexual offences that were recorded as having occurred on licensed premises.

Problems with police data

There were anomalies on the spreadsheet involving either the sex or age of victim not fitting the offence recorded or knowledge of offender not fitting classification of 'domestic violence'. These had to be corrected by the police analyst reading through the police case notes. These were resolved in the following way:

11 cases the victim's sex had to be corrected.

18 cases on the original database had to be deleted as the actual age of the victim was less than 13.

5 cases were duplicates and had to be deleted

52 cases the age at the earliest date of the crime was recorded and the offence had to be changed.

4 cases the victim's age was incorrect and had to be changed

2 cases classed as 'domestic violence' the offender was changed to known.

Vulnerable Victims Advocacy Team (VVAT)

VVAT do not have computer records and to collate data would require hand-counting. They have reported that at the moment the team are working to capacity and are just about keeping on top of their work. Therefore, they apologise that at this time they are not able to provide any data.

Multi-Agency Risk Assessment Conference (MARAC) Data

MARAC is part of a coordinated community response to domestic abuse. MARACs are voluntary meetings where information is shared on the highest risk cases between representatives from local police, health, child protection, housing practitioners, Independent Domestic Violence Advisers (IDVAs) and other specialists from the statutory and voluntary sectors. A co-ordinated safety plan for each victim is then created.⁵⁴

At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is represented by an IDVA who speaks on their behalf.⁵⁴

All MARAC Leads in each Local Authority on Merseyside were asked for data on cases between January 2008 – December 2010.

Table 22: St Helens MARAC from Jan 2008 – Dec 2010

MARAC	Gender	Age	Offence	Outcome
29/5/2008	Female	20	Alleged rape	Support from ISVA, later withdrew complaint
12/2/2009	Female	31	Alleged sexual assault	High risk DV case discussed at MARAC more than once due to repeat crimes, later discontinued
23/9/2010	Female	22	Alleged sexual touching during a domestic violence incident	Case went to Crown Court Dec 2010
18/11/2010	Female	40	Alleged rape	Referred to ISVA
2/12/2010	Female	41	Alleged rape	Referred to ISVA

Source: St Helens MARAC

St Helens Community Safety Partnership (CSP) has recognised the need to support and coordinate domestic violence services, and as part of this the CSP has supported the development of the Rape and Sexual Abuse Support Centre including ISVAs.⁵⁵

Liverpool are unable to send MARAC data as they have only just started to collect data on sexual violence, therefore they have no cases for this time period and only have four cases at present. Knowsley and Sefton were unable to send data because

it was not electronically recorded. On Wirral as their IT expert has left they have been unable to retrieve sexual violence data from their system.

Armistead Centre

Unfortunately data on sexual violence is only recorded on case files. Therefore, they were unable to provide information at the time requests were made.

Other Health Service Data

Merseyside Information Service has forwarded Ambulance Service call-outs that involve sexual violence on Merseyside. Unfortunately, they are unable to separate common assault from sexual assault and rape in their statistics.

The Trauma Injury Intelligence Group (TIIG) that collects data from Merseyside A&E departments does not have a category for sexual abuse therefore cannot supply data for this report.

Sexual Health Services – it is the opinion of services visited that they do not collect sexual violence data. However, the Abacus, Knowsley and Great Charlotte Street sexual health services (Liverpool Community Health provided services) do record this on their IT system as part of the consultation.

Some key issues reported to the researcher

Forensic Medical Examiners – These are supplied by Merseyside Police, who advertised in early February 2011 for more Forensic Medical Examiners (FMEs). They require urgent cover for some days of the week and for FME's holidays. Unfortunately, it takes a long-time to train an FME and to get Criminal Records Bureau (CRB) clearance. FMEs usually also have other work commitments which can make FME rota cover difficult at times. It is also difficult to provide cover for holidays. Indeed, one third sector agency has reported that a client was told they may have to wait 6 hours for a forensic examination in February 2011. However, there can be many reasons why someone might have to wait (from alcohol levels/consent issues, someone else being in SPM (they can only see one person at a time), to it not being necessary to bring people in SPM in the middle of the night.

Young teenagers - SPM is seeing clients who are young teenagers. Many young people see themselves as adults and have an issue with presenting at a children's hospital. Also, the Rainbow Centre is not seen as a discrete service as it is common local knowledge what the Centre does.

Counselling is now required sooner because of the efficiency of the Unity Team. RASASC provide time limited counselling then they refer on to appropriate mental health services. RASA provide counselling for as long as it takes.

Counselling for men is limited in Liverpool and the Wirral. There is a huge psychological support issue for men. Through anecdotal evidence, there is much under-reporting and many historical cases presenting for help. Many will not want to go to the police if an illegal substance has been used or they want to avoid the shame of going through a court case particularly if they are a family man. There is also an issue of domestic violence in same sex couples. Although SPM will provide an excellent service for males and will refer appropriately, it was felt by one service provider, their publicity is not explicit enough in male society. Marketing needs to be available in pharmacies, GUM clinics, drug services. The marketing needs to state that men do not have to report a crime to the police, as this would put a lot of them off visiting SPM for help. However, since 28th February 2011 there is a separate page dedicated to men on the SAFE Place Merseyside website also on poster cards and on buses that has made a difference.

Sexual violence intelligence - Sexual violence is not routinely asked about in other health service settings and data should be collected in future to provide an understanding of unreported offences. Coping with sexual abuse can lead to self-harm, drug and alcohol dependence, loss of self-confidence, depression etc. which creates an added burden to health services. Many sexual assault or rape survivors will report to other services with these problems, but sexual abuse is not being recorded. However, Abacus, Knowsley and Great Charlotte Street sexual health services (Liverpool Community Health provided services) do record this on their IT system as part of the consultation.

From experience of working with domestic violence victims, Sefton's Vulnerable Victims Advocacy Team (VVAT) has found that many victims normalise abusive behaviour and it is only after going through their risk assessment tool that sexual violence is uncovered. VVAT report that 90% of clients initially say they have not suffered sexual abuse then when they are asked specific questions they disclose. VVAT believe such a tool would be useful for other services to use so they can address long-term risks for their clients. This is one of the reasons they consider it is necessary to have **generic workers** in their team. Through using their screening tool a safety plan can be developed. The team does not agree that there should be a separate service elsewhere for domestic violence and sexual abuse e.g. IDVA and ISVA. There is also a separate Merseyside police unit for domestic violence: Family Crime Investigation Unit. However, the National Support Team review recommends a separate service to maximise specialist functions as the skills for ISVAs are different from IDVAs.⁴⁹

Awareness raising of SPM Services- Specialist campaigns are required to raise awareness in other services of SARC services for doctors and other health workers, teachers, university/college counsellors, social workers and drug and alcohol teams. However, the recent website has started raising awareness in other services as SPM has started receiving referrals from these agencies.

Post SARC support for adolescents - Post SARC support after attending the Rainbow Centre and SPM is required for adolescents. There are no specialist ISVA services for adolescents. Although RASASC provides counselling for young people and there is now a CAMHS team for 17-18 year olds.

Crime Prevention for sex workers in parlours and escorts - Through lack of an outreach service, there is no crime prevention for sex workers working in massage parlours and for escorts. There were two rapes reported in January 2011 in Liverpool parlours. This is alarming as no indoor rapes have been reported since 1999 in such places.

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