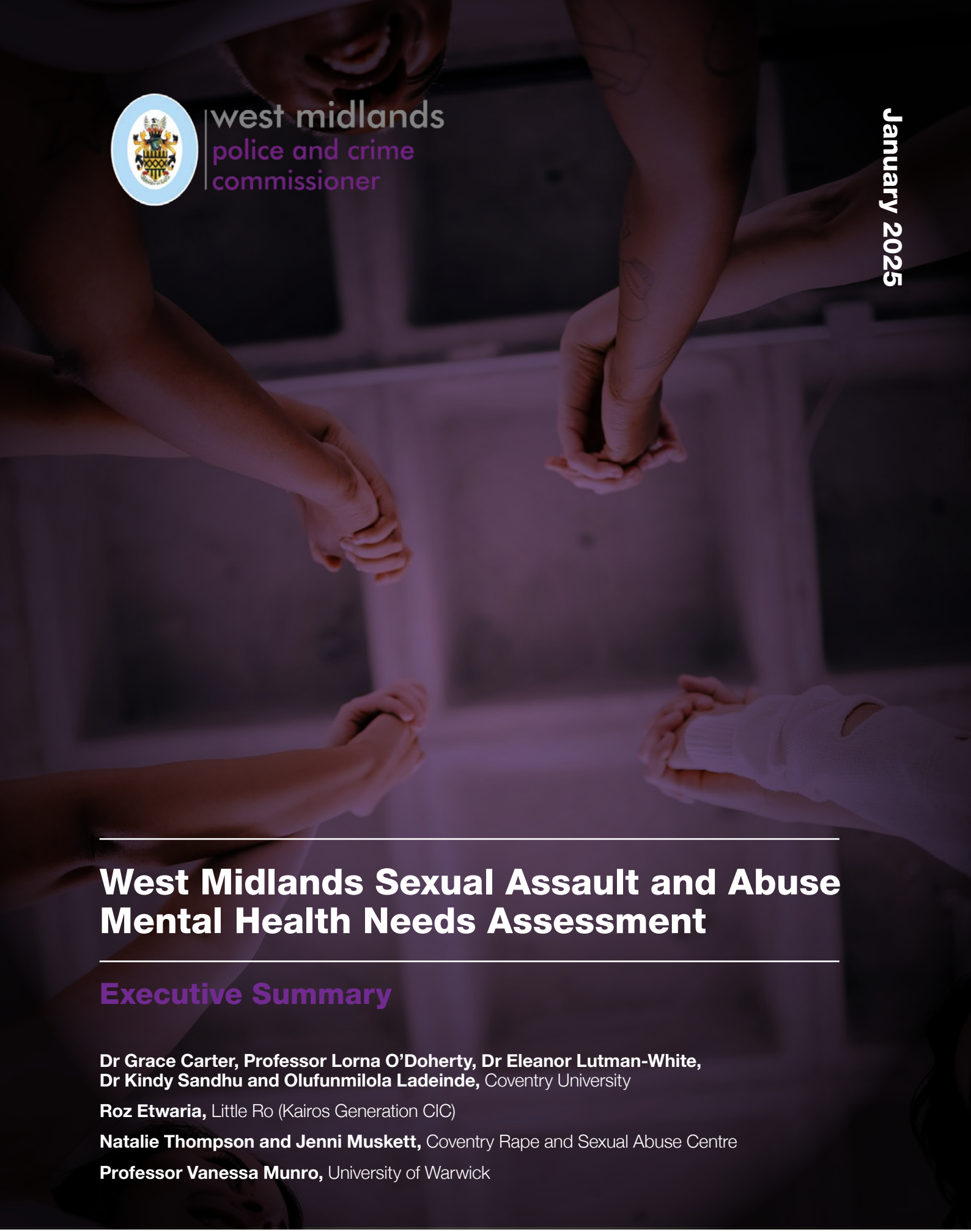

west midlands police and crime commissioner

January 2025

West Midlands Sexual Assault and Abuse Mental Health Needs Assessment

Executive Summary

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WARWICK THE UNIVERSITY OF WARWICK

CRASAC COVENTRY RAPE AND SEXUAL ABUSE CENTRE

LittleRo.org help hope healing heard

KAIROS GENERATION CIC ACTING NOW NOT LATER

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https://www.westmidlands-pcc.gov.uk/competencies-training-and-development-framework/

For access to the full report, please contact wmpcc@westmidlands.police.uk

Acknowledgements

This project is deeply rooted in the lived experiences and invaluable insights of survivors of sexual assault and abuse, as shared through the project's VOICE group, facilitated by Roz Etwaria. We extend our deepest gratitude to the group members for their unwavering commitment in identifying key mental health priorities for survivors. Their contributions were instrumental in shaping both the analysis and the final reporting of the results.

Professionals and agencies across sectors in the West Midlands showed a keenness to contribute insights and experience to this work, and their contributions are acknowledged.

We thank staff from the WMOPCC for their support throughout the duration of the project and for facilitating our engagement with key stakeholders.

This project is an important opportunity to activate research evidence developed within the NIHR-funded MESARCH project (2018-2023; 16/117/04) into recommendations for practice. We remain committed to ensuring the participants' contributions are channelled into policy and practice that concern survivors of abuse.

Funding statement

With funding from NHS England, the West Midlands Office for the Police and Crime Commissioner (WMOPCC) invited tenders for a research partner to conduct an assessment of the mental health needs of survivors in the West Midlands. The purpose is to support multi-agency partners improve their pathways, provision and strategic and tactical responses to sexual assault and abuse, as laid out in the West Midlands Sexual Assault and Abuse Strategy 2020-2023 and the NHSE Strategic Direction for Sexual Assault and Abuse Services 2018-2023. A partnership including Coventry University, University of Warwick, Coventry Rape and Sexual Assault Centre and Little Ro was awarded the funding and undertook the work between March and August 2024.

Use of language

This project aims to model intentional, sensitive communication related to sexual assault and abuse. Our approach to communication is informed by research, practice and the VOICE group which guided and supported the project. Below, we present some key terms used in the report and provide the rationale for their use. We acknowledge that language is constantly evolving and that preferences vary across communities and individuals with lived experience of sexual assault and abuse.

We use the West Midlands Sexual Assault and Abuse Strategy[1] **definition of sexual assault and abuse** as "*any behaviour perceived to be of sexual nature that takes place without consent or without understanding. It encompasses a broad range of activities, physical, visual and verbal, that are: of a sexual nature; take place without consent or without understanding; are experienced, at the time or later, as a threat, invasion or assault and that take away the ability to control intimate contact. Whilst sexual violence has been recognised as a cause and a consequence of gender inequality disproportionately affecting women and girls, we recognise [that heterosexual men and LGBT+ people also experience sexual assault and abuse].*"

Any person in the research who has experienced sexual assault and abuse is referred to as a **survivor** or someone with 'lived experience' of sexual assault and abuse. These terms were preferred by those we engaged with during the project. However, not everyone who has experienced sexual assault and abuse would choose to describe themselves in this way.

This needs assessment focuses on the **mental health** needs of individuals who have experienced sexual assault and abuse, recognising that the impact on mental health and wellbeing is often one of the most enduring and disruptive consequences. While references to 'mental health' were largely acceptable to the survivors we consulted, the term is used with care, and recognised as highly value laden. For survivors of abuse, mental health terminology and contexts may be associated with disempowering practices, secondary victimisation and additional risk. Key examples include: (i) the exploitation of mental health 'diagnoses' and help-seeking for mental health needs by perpetrators to further isolate and control survivors; (ii) the historical over-medicalisation of trauma; and (iii) diagnoses such as 'Borderline Personality Disorder', which carry stigma and may further marginalise survivors and hinder the healing process.

Complexity in relation to mental health is cumulative and not dictated by diagnosis alone. **Complex mental health** is seen to be influenced by several factors including the nature, duration and severity of mental health problems (including comorbidity and neurodevelopmental disorders); co-occurring drug and alcohol problems; co-occurring physical health problems; availability/quality of social networks; functional impairment; effectiveness of treatment or support; and services' ability to engage with people and be accessible[2]. **Complex trauma** or **complex PTSD**[3] refers to the ways people adapt to exposure to prolonged, repeated or severe traumatic experiences. The term 'complex trauma' is relatively acceptable to survivors, seen to acknowledge the extreme psychological demands engendered by exposure to abuse, and the heterogeneity of survivors' experiences. These terms emerged alongside concepts of trauma-informed care and practice, which are generally welcomed by survivors as alternatives to medicalising their experiences.

In our discourse, we use **racialisation** to highlight the marginalisation of people due to racial identities. The work recognises the structural nature of inequality and emphasises that race is a social construct, shaped by historical and contextual factors rather than purely biological differences. Our approach aligns with a parallel regional needs assessment[4], which underscores inequities and systemic racism in the availability of care, support, and healing for racialised survivors.

1. West Midlands Sexual Assault and Abuse Strategy 2020-2023
2. NHS England (2019) Mental Health Community Mental Health Framework for Adults and Older Adults
3. NICE Guidance for PTSD
4. Sexual Assault and Abuse Needs Assessment for Racialised Communities in the West Midlands (2024)

Imagine not feeling safe in your own body because your body is a crime scene; imagine re-living the sexual abuse you suffered every night in your sleep, waking up each day with a heavy weight on your chest—the memory of what happened. Sexual abuse leaves deep-rooted scars that become woven into the very tapestry of your being; it shreds your soul and leaves you so traumatised that you are left as a fragmented version of yourself, constantly sifting through the pieces to find who you were meant to be. It goes beyond the physical. It disrupts your mind, making you feel lost, isolated, alone, ashamed, and afraid. Trust becomes a distant dream, and relationships feel like walking on eggshells. It's like carrying a secret burden that no one else can see. And it doesn't stop there. Victims of sexual abuse struggle in school, their minds distracted by the trauma. Careers suffer too—how can you focus on work when your heart is still healing? But healing is possible. It takes time, support, and understanding, yet our professionals, NHS services, and society are often ill-equipped to provide this.

Sunflower Oak, contributions from the VOICE group

Background

Positive mental health, as a resource for living, is vital for a healthy, productive and resilient West Midlands population. The World Health Organisation[5] defines mental health as *"a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in."* Mental health is shaped by biology; personal experiences, circumstances and resources; relationships with family and others; the values, protections and opportunities that communities offer; access to healthcare and sources of help; and economic conditions and the social and cultural fabric of our society.

Exposure to sexual assault and abuse at any stage across the lifespan is a substantial threat to a person's mental health and wellbeing. The Crime Survey for England and Wales data for the year ending March 2024 estimated 2.6% of people aged 16 to 59 years had experienced sexual assault (including attempted offences) in the last year[6]. Based on population size of 1.84m in the West Midlands region, it is estimated that around 40,000 people experienced sexual assault in the last year, with approximately 300,000 citizens having an exposure to serious sexual offences during their lifetime. For survivors aged 16 years and above, just under half of sexual assault and abuse is perpetrated by partners/ex-partners. Sexual assault and abuse disproportionately affects women and girls (3 in 4 survivors are women) and those with diverse sexual and gender identities. Thus, maintaining a gender lens is vital alongside understanding that causes of sexual violence are multiple, and transcend all gender, age, sexuality, social, cultural and class categories.

There is global consensus about the contribution of sexual assault and abuse to the overall burden of trauma and poor mental health within communities and across nations, with growing recognition about its consequences for long-term physical health. Despite a steady unfolding of high-profile cases, international social media campaigns and redoubling of efforts to tackle abuse at multiple levels, there has been no reduction in the incidence of sexual assault and abuse over the past decade: neither nationally nor in the West Midlands. Positive change in people's reporting of incidents to the police is somewhat undermined by a loss of confidence in the criminal justice system to progress and prosecute cases. Moreover, sexual assault and abuse continues to be associated with stigma, blame and shame for survivors; and its role in producing and aggravating inequalities and deepening inequities between groups is not adequately understood or acknowledged. There is also a persistent lack of accountability in how professionals, institutions, the media and the values of organisations and communities reinforce the silencing of abuse that allows perpetrators to act with impunity and isolates survivors from opportunities to escape abuse or move forward in their lives. Efforts to prevent and prosecute sexual offences must be matched by access to appropriate health and psychological care and social and justice services for survivors of abuse. Part of this is recognising how institutional and professional responses can cause undue distress, aggravate mental health problems, and lead to missed opportunities for supporting the healing process. Mental health care is central to the national and regional response to sexual assault and abuse. A high proportion of people in contact with mental health services have experienced sexual assault and abuse. UK survey research reported that 40% of women patients in contact with secondary mental health services experienced rape/attempted rape as adults, and 10% had experienced sexual assault or abuse in the past year[7].

This needs assessment builds on existing regional initiatives to tackle sexual assault and abuse, setting out survivors' multifaceted experiences of mental health and healing. It articulates needs of survivors and uncovers gaps in provision of mental health care from the perspectives of survivors and a number of select agencies identified in the West Midlands region. In articulating survivors' priorities for their mental health and wellbeing, this assessment of need is intended as a tool for the NHS, local authorities, and agencies that work with survivors across multiple settings to prompt new ways of tackling barriers to access and engagement including strengthening interagency collaboration; boost mental health service design for survivor-centredness; and enhance the offering and choices for survivors of sexual assault and abuse in all settings.

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5. WHO Mental Health Key Facts
6. ONS (2024). Crime in England and Wales: year ending March 2024.
7. Khalifeh H. et al. Domestic and sexual violence against patients with severe mental illness. Psychol Med. 2015 Mar;45(4):875-86.

Approach

The needs assessment study was undertaken to establish the healing needs of survivors of sexual assault and abuse across seven West Midlands boroughs (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton). A mixed-methods approach was adopted to optimise the nature of data gathered with the available opportunity:

(1) Secondary analyses of longitudinal data from the MESARCH project (2018-2023)[8] drawing on data concerning mental health and healing among survivors of sexual assault and abuse over a one-year period (n=335, 10% lived in the West Midlands) and qualitative data gathered about mental health and support experiences among marginalised survivors (n=42 interviews, with 20% with survivors living in West Midlands).

(2) Structured interviews with experts in specialist sexual assault and abuse services and non-specialist, voluntary sector settings identified through mapping services and stakeholders in the West Midlands (n=11). We engaged professionals across local authorities (n=2), health (n=3) and criminal justice agencies (n=3) about the 'big picture' landscape of supporting survivors in relation to mental health.

This research was underpinned by trauma theory. Consistent with Judith Herman's framing of recovery, healing from sexual assault and abuse is conceptualised as both a process and outcome that involves empowerment of the survivor and restoration of relationships[9]. As with risk for sexual assault and abuse, healing involves an interplay of the individual and their circumstances, characteristics and environment, and thus drawing on intersectional theory[10] was important for guiding, interpreting, and reporting on the needs of survivors. The work was co-led by a survivor who identifies as part of Black and People of Colour (BPOC) communities. BPOC members of the VOICE group share this label. Our partner, along with the group, uses the term BPOC to reflect these experiences, while remaining committed to amplifying the voices of all racialised communities. This individual facilitated the involvement of 13 culturally diverse survivors, who have accessed services in the West Midlands.

The breadth and inclusion of mental health professionals and other stakeholders had to be balanced against conducting the research in a timely manner and with appropriate approvals in place. This generated the main limitation – a lack of professional insights from the NHS (especially GPs, and all levels of statutory mental health services) to complement the survivor centred knowledge.

The secondary research did gather insights from people living in supported accommodation; with experiences of poor or insecure living conditions; and from individuals with sensory, learning and health-related disabilities. On the other hand, there was limited coverage of circumstances where survivors had experienced sexual assault and abuse within mental health inpatient pathways and custodial settings. The project acknowledges that safe environments are vital for all users of mental health services[11]. The findings provide a 'big picture' of the regional landscape; headline findings spotlight complex organisational, structural, cultural and communication issues which may warrant further analysis and stakeholder input for implementing change.

Finally, this work emphasises adults' experiences, including those who were sexually victimised during their childhoods. Whilst we included agencies and professionals who work with and support children, the voices of those under 18 years of age are absent from this work.

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8. O' Doherty, L. et al. (2024) Health and wellbeing of survivors of sexual violence and abuse attending sexual assault referral centres in England: the MESARCH mixed-methods evaluation. Health and Social Care Delivery Research, 12(35) https://www.journalslibrary.nihr.ac.uk/hsdr/CTGF3870/#/abstract
9. Herman, J.L. (1998). Recovery from psychological trauma. Psychiatry and Clinical Neurosciences, 52(S1), S98-S103.
10. Crenshaw, K. (2013). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum, 1989(1).
11. Sexual safety on mental health wards - Care Quality Commission (cqc.org.uk)

Key findings and recommendations*

Features of mental health experiences among survivors of sexual assault and abuse

I've got to be honest, [my poor mental heath] is a combination of being let down by systems and trauma. When these things happened to me when I was younger, I genuinely thought the police were there to help. Whereas now I know it's just down to me. So, it's survival mode.

Survivor and service user

The biggest issue is that the mental health services are so under-resourced. From our point of view as a charity, it is funding and the constraints on counselling. We are also concerned about the interlocking and overlapping needs of women, which doesn't look the same for everyone; it could be mental health alongside children being removed, conviction, being sent to prison. More women's centres are needed that can support women with these challenges and barriers they are facing in the community.

West Midlands charity (non-specialist sexual assault and abuse service)

We identified some important features of mental health experience among survivors of sexual assault and abuse that are relevant at the interface of survivors seeking care and support from different agencies and professionals. These features may be integrated into programmes to improve practice around care for survivors.

- Survivors of sexual assault and abuse are not a homogenous group and healing does not occur in a vacuum. Healing is shaped by personal histories and exposure to trauma; by access to health, social and psychological care and justice; and through the restorative potential of the social, economic and cultural contexts of survivors' lives.

- Healing from abuse is a non-linear process, and survivors may experience relapses in mental health difficulties at various stages in their lives.

- All survivors seeking mental health care benefit from trauma-informed, flexible, and integrated approaches.[12] Survivors are better supported when professionals can recognise and work with their diverse priorities. For example, it is crucial that providers can distinguish between needs related to chronic mental health issues and those stemming from sexual assault and abuse.

- Enabling choice and offering encouragement counteract the consequences of exposure to abuse and control that make it particularly difficult for survivors to seek support. Survivors are better supported when systems and approaches resist patriarchal, medicalised, or overly directive responses, and instead strive to be collaborative and survivor-centred.

* A summary of findings is reported here. For more detailed findings, contact the OPCC for the full report.

12. Survivor, family and professional experiences of psychosocial interventions for sexual abuse and violence: a qualitative evidence synthesis (2022)

Key strengths to build and sustain

I would say that mental health services have professional experience of people who've been through severe trauma which enables them to actually open up the field of decision-making. So having been in a vulnerable position where even making simple decisions has been almost impossible and having been coerced and controlled, the mental health services have done the opposite. They have actually opened up the field of decision-making, helped me see how I can be part of that decision-making process regarding what medications to take, what activities to fill my day with, and I would say that that's consistent as an inpatient and as an outpatient.

Survivor and mental health service user

Many professionals in the West Midlands work effectively with survivors of sexual assault and abuse across the NHS, other statutory services, and the voluntary sector. Alongside their skills and knowledge relevant to service delivery, these professionals promote safe environments, avoid making assumptions about what survivors need, demonstrate empathy, and remain committed to understanding survivors' priorities. They strive to offer options aligned with individual preferences, while also considering personal, cultural and structural barriers to engaging with support. Such approaches can significantly enhance treatment success and survivors' wellbeing and healing.

The region has areas of strong multiagency collaboration within and across sectors, helping to create more seamless care for survivors. High-level partnerships and initiatives in the region provide an infrastructure to drive improvements outlined in this report, by bringing stakeholders together, highlighting gaps and concerns, coordinating responses and monitoring change. The wider context can also facilitate change, for example, the Victim's and Prisoner's Act 2024[13] offers an excellent opportunity for police and crime commissioners, local authorities and integrated care boards to implement the recommendations through the 'duty to collaborate'.

We have been based in one local authority for a long time. We are known, have connections, we have been a longstanding member of the support services they offer, we are understood, they are aware of what we can do. With the other local authorities – we haven't been there as long – it's about building relationships with local authority partners so there is better infrastructure around the area that they are working in.

West Midlands specialist service provider

Survivors report benefits from receiving trauma-focused interventions (see NICE guidelines[14]) within the NHS. However, these may be less helpful to survivors with complex forms of trauma. The region provides a wealth of mental health-promoting services, interventions and groups for survivors. However, survivors often lack information about opportunities that exist as alternatives to, or after therapy, such as peer support groups, helplines, and online resources. Any system adequately prepared to meet the needs of survivors of abuse will be characterised by a diverse offering and use multiple approaches, disciplines and specialities, recognising the expertise within and across sectors and developing referral mechanisms to capitalise on this.

Best practice looks like working with lived experience – experts by experience being included at the table where decisions are made. Some services don't agree with this approach. Peer support is also very important, and this is often dismissed, but it helps to be around people with shared experience.

West Midlands charity (non-specialist sexual assault and abuse service)

There is growing recognition in the specialist services of incorporating the lived experience of sexual assault and abuse for service design and enhancement, and more awareness about the prevalence of sexual (and childhood and domestic) trauma within workforces across the region. The research suggests the value of supporting staff who are survivors and driving service improvements by drawing on expertise through experience.

13. Victims and Prisoners Act 2024.
14. Psychological interventions for the prevention and treatment of PTSD in adults

Problems requiring urgent attention and recommendations

We were thinking about like the crisis team. Trauma therapy for, say, complex trauma that may be linked to childhood sexual abuse, it's like a five-year waiting list. But in order to even access that, you need an actual diagnosis of, like borderline personality disorder or complex PTSD. There's not really a crisis response. We'll call them if we've got a woman who might be self-harming or talking about taking her own life. Then there's a call back, 'Call the police!' The police, they'll tell us to call the crisis team. We go back to the crisis team. The crisis team might do a call a few hours later. They're not going to go out and see the woman. I don't understand. What? In a crisis situation, what is their crisis response? I think that they're completely overstretched.

West Midlands charity (non-specialist sexual assault and abuse service)

The current landscape of service provision in the West Midlands does not adequately meet the mental health and healing needs of survivors of sexual assault and abuse. Though these gaps in service provision are not unique to the West Midlands region, there is a palpable drive and will amongst professionals and agencies to tackle gaps urgently and better meet the needs of survivors. The project identified 5 areas requiring urgent attention. Whilst several factors demand increased funding to address them, others like strengthening individual or institutional preparedness to support survivors of sexual assault and abuse lend themselves to more immediate, low-cost solutions.

1. **Poor recognition of abuse in communities of the West Midlands undermines access to care and healing.**
   Poor recognition or not asking about abuse means opportunities to intervene to stop abuse, provide a supportive response, and undertake follow-up and referral are lost. Where disclosure or identification of abuse does take place, currently, support pathways are not always clear to professionals and survivors, and survivors can be disillusioned by the responses they receive, even discouraged to seek help in the future.

Discussing bits and pieces that happened, after with GPs, was quite difficult. You're trying to say that you're unwell and you can feel it in your body. Like you just feel uncomfortable in your own skin. You always get this bog-standard response of 'we're not qualified in that area, to deal with those issues'. And that's always really disheartening because their response is speak to the police. It's on you and it's just on you. You have to go search for that help. That was the response that seemed to happen a lot. And then, after a while, you just stop asking because, what's the point?

Survivor and service user

- Organisations across the third sector, health and local authorities and other public sector services must recognise they may be providing services to survivors and should be equipped to do so relative to the duties of their role or goals of the organisation. There needs to be continued investment in developing awareness of sexual assault and abuse, its presentation, intersections and impacts on the person, and appropriate responses to service users where trauma may be a factor.

2. **Prolonged wait times in all sectors and arbitrary thresholds for accessing NHS mental health care are the most significant access problems**.
   Restrictions on the number of sessions and abrupt discharge from care are also pressing concerns. Those with the greatest need and vulnerability are most likely to struggle accessing appropriate mental health care.

I find that when we are at our most ill especially with mental health, it's the most difficult time to access services, it's a conundrum.

Survivor and service user

- Funding must prioritise the problems of access to crisis care and community mental health. Long waits for counselling in the third sector must be tackled to allow survivors access to support within 1-2 months.

- Commissioning services for longer periods will promote stability, by allowing longer-term strategies to address gaps and challenges, reducing staff turnover and promoting consistency in the provision of support to survivors.

- Service providers need to prepare survivors sensitively and proactively for change, for example, where a treatment approach is not producing the desired effect, a practitioner is leaving their role, or support is coming to an end. Supported transitions empower survivors to continue their healing process despite disruptions.

- Introduce novel ways of 'holding' survivors who are waiting to access support. Establish what survivors see as priorities for their support, and offer interventions that promote self-care and maintenance of wellbeing, especially among those with needs below clinical thresholds. This could include initiatives for strengthening peer support networks and access to support for survivors' families. Empower survivors through provision of accessible information about options, informed by lived experience[15].

- Concerted measures are needed to embed knowledge and evidence about enhancing mental health care access in marginalised groups including those from racialised communities in the region. This requires developing not only cultural competence but approaching cross-cultural care and support of survivors with cultural humility.[16] Similar models can be developed for working with survivors from other marginalised groups.

- Further research is needed to identify the access experiences of children and young people in the West Midlands, and to evaluate current service provision.

3. Medicalised models of mental health care are unsuitable for survivors of sexual assault and abuse.

In one study, 15% of survivor participants found aspects of NHS care harmful to them in the aftermath of sexual assault and abuse.[8] Whilst the evidence shows that many survivors benefit from the mental health care they receive, too many experience a mismatch between what they say they need, and the approaches used and therapies offered.

> *When I said that I had complex mental health, the woman counsellor said, 'Well, we only really deal with people with anxiety and depression'. She started to obsess about my mental health when I started sessions with her on the phone. I said, 'Actually I'm not here to talk about [mental health], it's to do with the sexual assault'. It was as if you couldn't actually access that service if you had a complex mental health diagnosis, and in the end, I stopped it, because I felt it was making it more detrimental.*
>
> **Survivor and service user**

- Survivors will benefit from expanding access to evidence-based interventions, therapies and support services. This could include a blend of traditional trauma approaches, psychotherapies, alternatives to 'talking' therapies such as trauma-sensitive yoga, art-based approaches, and nature- and faith-based interventions and peer support.

- Services/practitioners need to work with existing NICE guidelines on caring for adults with complex trauma and be responsive to emerging evidence for this subgroup. Building knowledge and practice around relational healing and 'pro-healing environments' may help to shift settings and practices away from the limitations and harms associated with over-medicalisation.

- There is strong potential for transferring learning in mental health settings to benefit survivors/service users accessing other health settings like emergency and maternity care.

15. Therapies for mental health and wellbeing after exposure to sexual violence and abuse: information for survivors and their supporters
16. Sexual Assault and Abuse Needs Assessment for Racialised Communities in the West Midlands (2024)

Incredible, absolutely amazing: with the [Talking Therapies] therapist, she's just easy to talk to and you know she is taking it in and listening rather than taking a medical route. I am over scales and checklists; I sit with her, we do meditation. The medical way is not for me. I suffered with mental health since I was about 12. I wasted a lot of my life with the wrong people, wrong environment, wrong medication.

Survivor and service user

4. Survivors' healing needs are multiple and benefit from agencies working well together.
A person who is receiving counselling may not progress particularly well if they are living in poor housing conditions or situations which place them at risk of further harm or abuse. Within health, survivors may experience 'revolving door' effects where they pass from primary care to secondary services and are discharged back to the GP. This can have detrimental effects on wellbeing especially where survivors feel responsible for a lack of progress or treatment effect. Advocates, ISVAs and care coordinators play a vital role in connecting survivors with what they need however the systems themselves need to hold people more effectively, provide more reassurance and continuity.

But the backbone of all my support, and that I fundamentally owe my life to, is my care coordinator. She is technically a social worker but works in the mental health service. She is the only person I've ever encountered in my life, who other than my mum, that I can say fundamentally believes everything that's happened to me and is in my corner. Many times mental health services have tried to stop my therapy or support because I've been under them a while. She is the sort of person that will stick her neck out to anyone if she thinks she's right in fighting a justified battle.

Survivor and service user

- Organisations can maximise their contribution to survivors and the communities they serve when they are integrated and working well together through mutual respect, effective communication, and co-defined pathways.
- Commissioning processes need to account for the wide range of needs survivors have and recognise these are met by the differentiated skills, knowledge, orientations and cultural competencies of different sectors, and the organisations and people within them.[17]
- Some survivors will benefit from NHS provision whilst others will require approaches offered by the voluntary sector, and within this sector, some survivors might choose therapeutic approaches whilst others lean towards non-therapeutic interventions.
- Adopting an integrated holistic approach to healing should encourage coordination of care between agencies rather than viewing and responding to needs in isolation.
- There needs to be a commitment to developing more robust multiagency partnership working between primary care, mental health, SARC, third sector, justice, local authority, integrated care boards and police and crime commissioners so that professionals have the awareness and confidence to support survivors through clear support pathways, are aware of the full role of specialist sexual assault and abuse services, and can coordinate/communicate about care with other professionals.

[Ideally, health services] would contact the partnership...that warm handover, making sure that there was a trauma informed process for the woman to be able to access the right support from the other services without her being being passed around to a lot of referral partners and having to repeat herself and be put in new situations where she doesn't know anybody and feels really uncomfortable.

Specialist third sector provider

17. What does the evidence say about the effectiveness of interventions for people exposed to sexual violence and abuse? A briefing for commissioners

5. **Gaps in trauma competent practices and communication in all settings are counter to tackling the effects of abuse.**
   Poor responses lead to distress, re-traumatisation, secondary trauma, withdrawal from health and other care, and increase survivors' risks of harm. The ways in which professionals interact with survivors, their views and assumptions about mental health, and the ways in which survivors experience the responses of services and systems all have an impact on mental health and healing. It is not uncommon for survivors to feel they must choose between their mental health and rights to justice. There is recognition that even the basics of trauma-informed principles may be absent from working practices, particularly in policing and justice. Use of trauma-informed practice may assist with reducing attrition in sexual offences cases.

I think as soon as I told them [two police officers], 'I've got mental health issues', their attitude changed towards me. They said, 'Well if this does go to court, yeah, your records, your mental health records will be shown to the courts'.

Survivor and service user

- There is a need to train professionals across relevant sectors in communicating about sexual violence and with survivors of sexual assault and abuse. Training needs to draw on multiple sources including research evidence, lived experience and professional expertise in supporting the healing of survivors.[18]

The police have been very good, they have been taking time to go to my house to do the second interview...they have given me time to recover.

Survivor and service user

- Whole systems approaches are required for effectively embedding trauma-informed principles in organisations (particularly local authorities and NHS) and increase commitment and enhance the capacity of staff to build trust with service users/survivors in an open, supportive, empathetic, accepting and non-judgmental way.

- Specialist sexual assault and abuse services can play a critical role in sharing knowledge and skills with other agencies, including more affordable, trauma-informed techniques in responding to survivors' support needs, techniques that can be trained by practitioners and can be practiced by individuals.

- A standard for evaluating the extent to which services fulfil mental health needs and promote wellbeing of survivors needs to be prioritised going forwards.

18. What does the evidence say about the effectiveness of psychosocial interventions for people exposed to sexual violence and abuse? A briefing for providers and practitioners

Conclusion

An urgent response to the gaps identified in this report is needed to stem deepening health inequalities and tackle the economic and social disadvantage associated with abuse for survivors of sexual assault and abuse in the West Midlands. Poor mental health is itself a source of disadvantage when met with discriminatory responses. It may reduce a person's capacity to access health and social care and justice in the aftermath of sexual assault and abuse.

There is a solid and growing evidence base to support a range of psychosocial interventions for survivors' mental health and wellbeing. However, funding remains a barrier to the delivery of personalised and timely care as well as the provision of lifelong psychological support. Access to psychosocial care and support is sparse relative to demand, and the stepped mental health care model of the NHS does not consistently meet survivors' varying needs. Survivors alternate between being "too complex" for primary care and not meeting thresholds for secondary services. NHS settings can be experienced as disempowering for survivors of abuse, and the damage caused through these interactions is not sufficiently acknowledged or understood by practitioners/clinicians.

Professionals working in non-specialist sexual assault settings can miss signs that a person is a survivor of abuse or be dismissive when abuse is disclosed. They may lack awareness of referral care pathways locally. The day-to-day interactions survivors have with housing services, their GP and other healthcare providers, as well as with police, justice, social services, workplaces, and social networks, are vital for achieving lasting positive outcomes.

Professionals and agencies across all sectors must not only understand the prevalence and impact of abuse but also actively develop the skills and knowledge needed to support survivors effectively. Holistic integrated care pathways are significantly valued by survivors but need considerable development regionally along with a commissioning model that promotes partnership and shared goals between agencies. Sensitive, transparent, responsive communication and collaborative care are cornerstones of trauma competent practice. The project calls for innovative, whole system approaches to building survivor centred mental health care and the fostering of restorative practices, settings and workforces for the West Midlands.