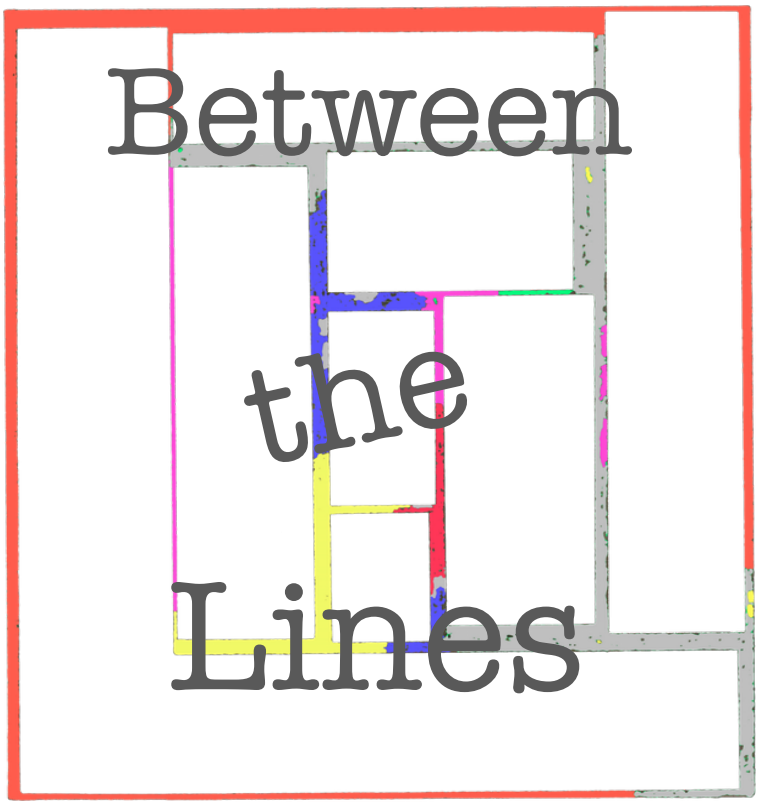

Service Responses to Black and Minority Ethnic (BME) Women and Girls Experiencing Sexual Violence

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imkaan

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Acknowledgements

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Introduction

There has been increased political attention given to the issue of sexual violence and a greater recognition of its impact on individual health and social wellbeing. However, there is an uneven knowledge base about how it affects some sections of society. To date, little research has been done on the experiences of sexual violence among black and minority ethnic (BME) women and girls, who are among the most disadvantaged sections of society. This makes it difficult to assess the nature of sexual violence experienced, its impact on women's wellbeing, disclosure patterns and help-seeking, and the responses received from services by these groups.

Despite an enhanced criminal justice approach, sexual violence[11] remains among the most common yet under-reported[12] and poorly prosecuted crimes in the UK. However, the criminal justice system's (CJS) treatment of and response to survivors remains a key concern and various efforts are being made to improve rates of under-reporting, attrition, prosecution and conviction.[13] Alongside this, lobbying and research conducted by feminist academics and key sexual violence support organisations, such as Rape Crisis England & Wales (RCEW), have drawn attention to the importance and value of specialist and dedicated support to survivors whilst also identifying significant gaps and threats to the sustainability of rape crisis services.[14] A number of central government reviews, including the Stern Review (2010) on the handling of rape complaints[15] and Sara Payne's review of 'victim' experiences (2009) have also highlighted the need to improve the provision of support services for survivors beyond the CJS.[16] The growing public policy awareness of the vulnerability of and gaps in sexual violence services consequently led to the development of a centralised government funding stream, the Rape Support Fund.[17] Sexual violence remains a key public policy concern, particularly in light of a series of high profile scandals and historic failures involving public figures and institutions which has resulted in greater criticism and scrutiny of the role of public bodies and their responses to survivors of sexual violence.[18] Undoubtedly some progressive steps have been taken to address policy and service gaps in responding to sexual violence. However, in relation to BME survivors of sexual violence, whilst a number of government commitments have emerged within the context of international violence against women and girls (VAWG) policy,[19] there has been little consideration within domestic national and local policy frameworks of the specific barriers and experiences of BME women and girls, which would merit specific policy approaches and service responses[20] to address any inequalities in access to specialist support in a UK context.

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11 While different definition of sexual violence exist, perpetrators may include strangers, intimate partners, family members, friends and peers or other acquaintances, such as through community or online networks. In relation to BME women, it is recognized that sexual violence can also occur within the context of forced marriage,'honour-based' violence and female genital mutilation and be linked to gang contexts and sexual exploitation.

12 In 2011/12, 53,700 sexual offences were recorded by the police in England and Wales, of which the most serious sexual offences of 'rape' and 'sexual assault' accounted for 71 per cent. Only around an estimated 15% of women who have been raped or sexually assaulted report it to the police and only 6.8% of all rape cases end in a conviction (Ministry of Justice, Home Office and ONS, 2013, An Overview of Sexual Offending in England and Wales: Statistics Bulletin, January).

13 The CPS convened a rape scrutiny panel to address the fall in the number of rape-flagged cases referred by the police to the CPS See:

14See End Violence Against Women Coalition and Equality and Human Rights Commission Map of Gaps (2009), which revealed a stark picture of Rape Crisis provision in Britain. Nearly 9 out of 10 (87.7%) local authorities in Britain did not have a Rape Crisis Centre, leaving a significant number of women who have experienced sexual violence without essential care and support. See http://www.rapecrisis.org.uk/news_show.php?id=51

15 Stern reviewhttp://webarchive.nationalarchives.gov.uk/20110608160754/http:/www.equalities.gov.uk/PDF/Stern_Review_acc_FINAL.pdf

16 http://www.uknswp.org/wp-content/uploads/rape-victim-experience.pdf

17The national rape support fund was established in 2011 and is administered through the Ministry of Justice (MOJ). The Coalition government allocated £4M per year to support the sustainability of existing rape crisis centres and establish new centres where provision is lacking. Since 2010 the Coalition government has also allocated match-funding to help establish 15 new rape crisis centres. Funding has also allocated to help establish a further two centres in 2015.

18The Government set up a National Group to tackle Sexual Violence Against Children and Vulnerable People and a National Independent Enquiry was announced on July 7th 2014 to consider the role of public bodies and other non-state institutions in protecting children from sexual abuse18.

19 See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118153/vawg-action-plan.pdf which highlights the Government's international commitments to addressing VAWG.

20 See http://rightsofwomen.org.uk/wp-content/uploads/2014/10/Measuring_up-201.pdf

The overall paucity in research knowledge is unsurprising given the wider silencing of sexual violence in all communities but which can be especially marked in particular BME communities. However, it is likely that the reactions of significant others, individual decision making processes, as well as socio-cultural and political factors all intersect to enable or inhibit women's voice around this issue. Indeed, research on BME women affected by domestic violence shows that factors most commonly deterring disclosure are concerns about inappropriate agency responses, and the ways in which families and communities will respond and negatively construct women, and women's own construction of shame and social stigma. The domestic violence literature also reveals low levels of awareness about the existence of support services and it is likely that this is even more so in relation to sexual violence services.

Alongside the domestic violence literature, which allows some conclusions to be drawn, there is some literature about the disclosure of child sexual abuse (CSA) in BME communities, which generally argues that not only is it a highly under-reported issue but that professional responses to it are frequently inadequate. Practitioners recognise that BME women and girls are undoubtedly experiencing sexual violence and that there are a range of obstacles that prevent women from coming forward for help but that service responses to it are extremely limited. Moreover, the particularity of BME women's experiences as linked to multiple contexts – such as forced marriage, 'honour-based' violence, female genital mutilation, peer-on-peer abuse sexual exploitation within an individual or group and gang-based context – are frequently considered inadequately. The extent to which 'silence' may be a part of coping strategies or indeed shape the strategic choices women make about who they tell (if they tell), as part of the larger construction of what is speakable and silence, still needs to be explored. The ways in which 'shame' functions and has consequences for all women affected by sexual violence has been discussed by some writers but the ways in which it operates within particular communities has remained unexplored.

Research aims

Recognising the absence of research on BME women who have experienced sexual violence, this *initial phase* of larger planned research, conducted in partnership by the Centre for the Study of Safety and Well-being, University of Warwick and Imkaan, was aimed at:

- generating an initial body of evidence about the extent to which BME women and girls are disclosing sexual violence and accessing support services;
- gathering evidence on emerging barriers and gaps to accessing support.

Methodology

In order to achieve the research aims, a multi-method approach was used. A national mapping survey, developed in consultation with Rape Crisis England & Wales and Women and Girls Network and piloted with two rape crisis services, was administered to existing sexual violence services and a sample of specialist BME domestic violence services to collate data on numbers of BME women accessing services, support offered, any special measures developed, barriers in responding, and any gaps in service provision. Responses were received from 38 organisations.

Agency consultations and interviews with 10 professionals across different sectors with an expertise in sexual violence were also conducted to identify the key issues for BME women affected by sexual violence, the limitations and opportunities in professional responses to BME women, and how service responses can be strengthened.

Report

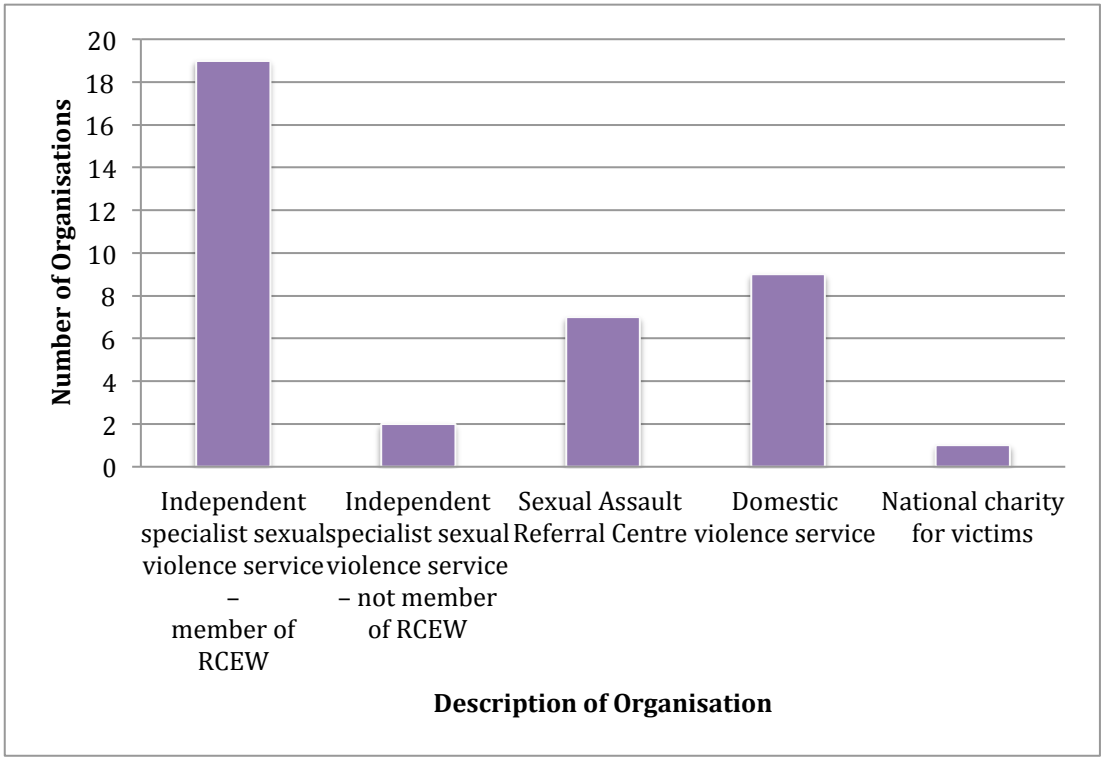
This report presents the findings from both the survey and professional interviews in two separate sections and concludes with key recommendations that arise from the overall research findings.

Findings from the survey

This section outlines the findings from the survey of sexual violence and BME domestic violence services[21] which 38 organisations responded to.

Type of organisation

Of the 19 independent specialist sexual violence organisations (members of RCEW), eight had specific services for BME women and girls. Of the nine domestic violence services, six were BME specialist organisations and of the three generic domestic violence/VAWG organisations which had sexual violence services, one had a BME specific service. If we look at the main beneficiaries, equal numbers (n=14) targeted only women and women and men. Of the nine domestic violence services, six were women only. Below provides an overview of the range of 38 organisations that responded to the survey.

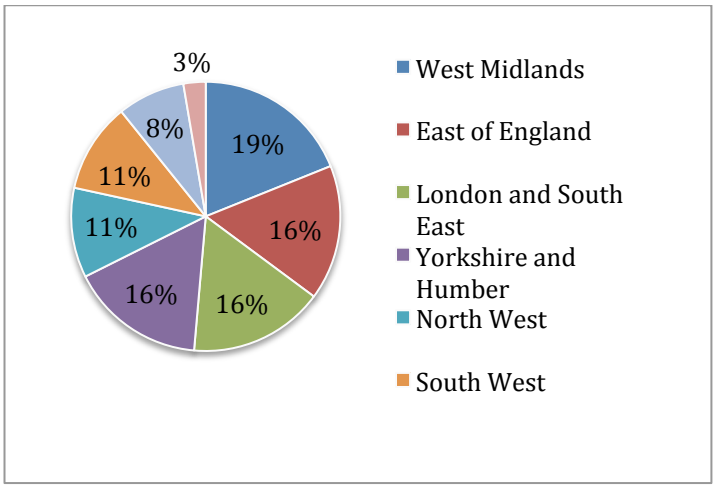


Graph1: Type of Organisation

Geographical location

In relation to geographical location, organisations in the West Midlands, Yorkshire and Humber, East of England, and London and South East, areas with substantial numbers of BME groups, provided the highest responses, as shown on the next page.

[21] We are aware that some BME domestic violence and sexual violence organisations increasingly refer to themselves as violence against women and girls (VAWG) services as they work with women and girls across different forms of VAWG.



Graph 2: Geographical location of responding organisation

Services for women who experience marginalisation

71% (n=27) of organisations said they offered specialist services to women who experienced specific forms of marginalisation. Fourteen of the 21 independent specialist sexual violence services, eight of the nine domestic violence services and three of the seven Sexual Assault Referral Centre (SARCs) said they provided services to women and girls who experience different forms of marginalisation.

Marginalised Women	Yes (%)	No (%)
BME Women	55.3	13.2
Women subject to immigration control	39.5	28.9
Women involved in prostitution	34.2	34.2
Trafficked women	28.9	39.5
Women recently released from prison/involved in CJS processes	23.7	44.7
Lesbian/Bisexual women	28.9	39.5
Transgender/transsexual women	23.7	44.7
Disabled women	34.2	34.2
Women in or from high conflict areas	31.6	36.8
Young women (14-18 years)	47.4	21.1
Older women	34.2	34.2
Women who present with significant mental health issues	44.7	23.7
Women who use drugs and alcohol	28.9	39.5
Women in rural and remote locations	31.6	36.8
Women with HIV/Aids	21.1	47.4
Women who cite 'honour' as a specific issue	36.8	31.6
Girls/women at risk of/fleeing forced marriage	39.5	28.9
Young women and gang association	34.2	34.2

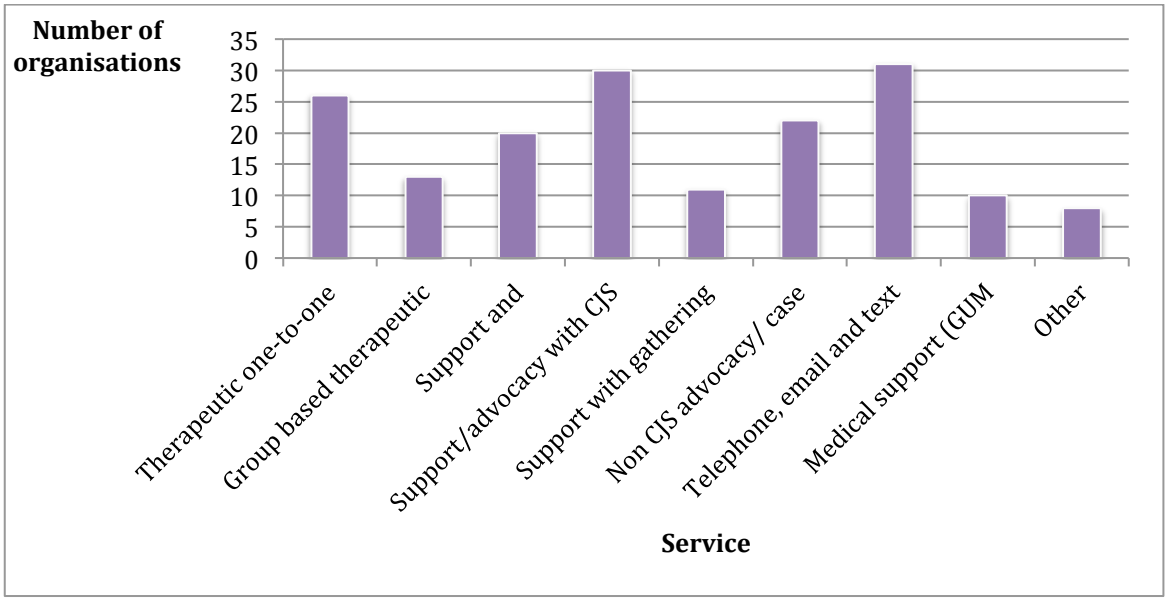
Table1: Organisations providing specialist services for specific forms of marginalisation

Given the complexity of women's lives, it was recognised that there may be overlaps between the categories of marginalisation. This was something commented on by respondents who said that many of the categories were issues that women presented to their service with. If not specifically aimed at particular groups of women, even though women presented with the range of issues, some organisations only ticked those categories where they had specialist workers. While some were clear they were '*a specialist sexual violence service'* and that they worked with all of the categories when sexual violence was the presenting issue, others reinforced the point that '*all of our services are accessible to all women over the age of 18 years'* and that *'we provide a service to all women regardless of race, culture, lifestyle, location etc.'*

It was evident that only a few services had considered what being *accessible to all women* actually meant in practice. Some said they simply signposted women to other services when unable to meet their needs, while a minority not only referred women to other suitable services but worked alongside them to provide the best support possible. They had put in place measures to support women to access their services, among which were travel costs for women with no recourse to public funds, support letters for women seeking asylum subject to dispersal, childcare and interpreters.

Nature of support

In relation to support provided, as detailed below, independent specialist sexual violence services were more likely to offer one-to-one therapeutic support, group-based therapeutic support and support and empowerment groups.



Graph 3: Nature of support

- Nineteen of the 21 independent sexual violence organisations offered one-to-one support, eight offered all three and seven offered one-to-one support and support and empowerment groups.

- Three of the seven SARCs offered these types of support, with two providing one-to-one support and one providing one-to-one and group-based support; none offered support and empowerment groups.

- Among the BME specific domestic violence services, support and empowerment groups were the most common form of support provided by four of the six services, with only one service offering all three types of support.

- Among the generic domestic violence services, one-to-one and support and empowerment groups were the most common forms of support provided by the three services.

Where organisations provided other services, this included support with education and training; helplines (sexual violence and domestic violence); body work for sexual violence and child sexual abuse (CSA); prevention training in schools and colleges; outreach service for BME women and communities; young women's service (13-19 years); training to/ group work with professionals and volunteers; community awareness; counselling for children under 12 years; learning disabilities group work; women's engagement in community activism; drop-in sessions, including for Asian women; and English classes.

Waiting times

Organisations offered support to survivors for varied time periods. Whilst many said the support offered depended on the situation of each woman and the length of the criminal justice process, counselling support and face to face support tended to be fixed for a period– ranging from ten weeks to two years though typically it tended to be for five to six months. Support through a group or helpline was usually not time limited. Even when fixed, support was extended by some services if required by women, especially if the CJS process was protracted. A minority of SARCs said they saw women for three to four hours before they were referred onto other services. Sixty one per cent (n=23) of organisations had a waiting list with the average waiting times varying greatly among services.

For Independent Sexual Violence Advocate (ISVA) support, waiting times were around two-four weeks; for counselling, between four weeks to six months, and where demand had increased this was likely to be at the longer end; and six to eight months for body therapy.

Waiting lists were managed by occasional calls (every two to three weeks to one to two months) to check if support was still needed or if the support was more urgent. Support continued through phone and email support; by inviting women to social groups and coffee mornings; initial assessment meeting and support through a helpline; support through ISVA; and one-to-one support for up to six sessions whilst waiting for counselling. Where women were prioritised, they were seen within six weeks and some services gave priority to girls under 16 years and women going through CJS processes. Women who had language needs had to wait longer due to the lack of resources for language counsellors.

Overview of sexual violence cases

With the exception of three services, all kept figures on the number of sexual violence cases.

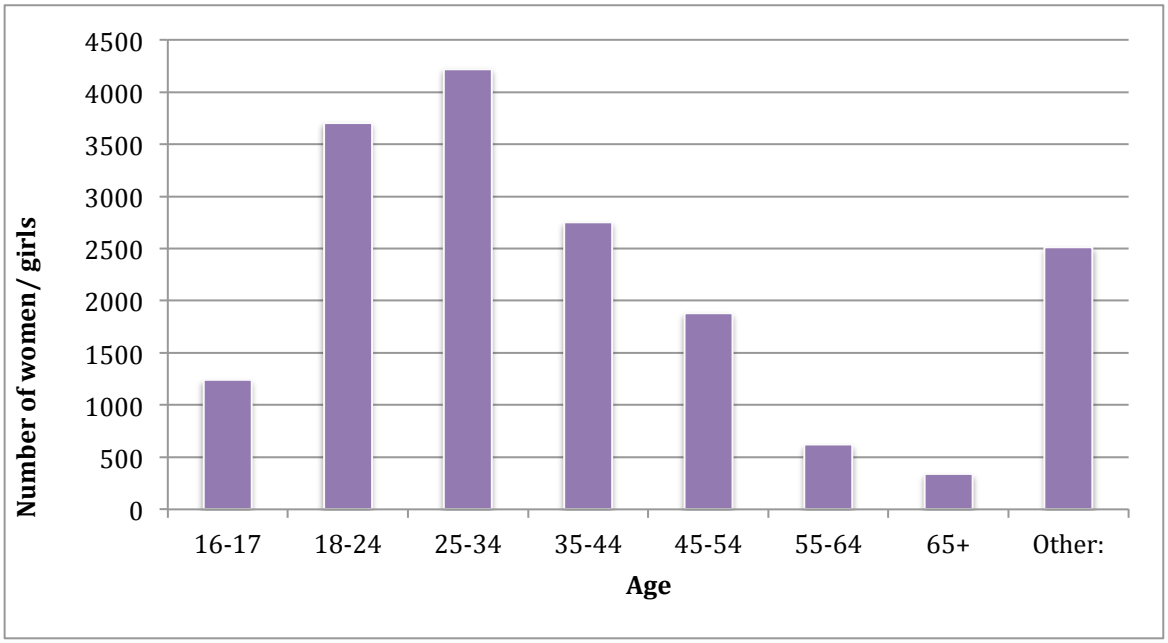
Table 2 below shows that organisations reported a total of 16,409 female sexual violence cases in the year 1st April 2013 to 31st March 2014, of which 15 per cent were disabled. The case loads of organisations varied greatly, with four reporting between four and 20 cases whilst the highest number reported was 4,000 cases. This reflects the size of the organisation.

The data further shows that 1,033 male cases were reported, of which 9.2% were disabled; only 7% non-binary/transgender cases were reported, with none of these being disabled. Of the 16,409 female cases, 3.91% described their sexuality as lesbian, 2.8% of the 1,033 men disclosed themselves as gay and 5% of all reported cases during the last year reported being bi-sexuals.

Female	16,409	2,454 (14.95%)
Male	1,033	96 (9.29%)
Non-binary/transgender	7	0
Total	17, 449	2,550 (14.67%)

Table 2: Gender and disability status

The age distribution of sexual violence cases[22] reported in the last year shows that the major groups of women and girls were in the age groups of 25-34 (24.4%), 18-24 (21.4%), and 35-44 (16%) years respectively.



Graph 4: Age of women and girls

BME cases

With the exception of one, all organisations said they recorded ethnicity and reported a total of 3,749 BME cases (of the total 16,409 female cases reported, constituting 22.84%). This percentage is possibly skewed by a greater number being seen by those organisations located in areas of high diversity. However, when asked for details about their BME cases, fourteen did not give a response, leaving a total of 23 organisations that provided information about ethnicity. One of these gave an approximate percentage of BME cases, leaving substantive responses from 22 organisations.

Responses indicate that there are gaps in the way that equalities data is collected, including on disability, sexuality and age. In relation to ethnicity, a wide range of different ethnic categories were used, making it difficult to be exact about the ethnicity of women and girls. A minority did not provide information about ethnic categories used but gave the overall number or percentage of BME cases which tended to be small. Some collapsed categories such as Black Caribbean and Black African, Asian and Asian British, which is likely to disguise needs. The low numbers of BME communities in some geographical areas were reflected in the organisations' figures, however, even in areas where higher numbers of BME groups were likely, organisations did not monitor ethnicity.

Table 3 provides as much detail as could be extracted from the wide ethnic categories reported, by integrating some of the categories, as indicated. It shows that ethnicity was recorded for 3,615 service users, with Asian/Asian British comprising the largest group, followed by Black African, Mixed/Multi-Ethnic/Dual Heritage and Black Caribbean.

[22]The results show a discrepancy between the total number of sexual violence cases reported (17,449) and the age distribution (17,270), which may mean that these organisations did not have the age-data of 179 cases.

Ethnic Group	Total No. (%) of women and girls
Asian/ Asian British	924 (25.56%)
Asian other	36 (0.99%)
Bangladeshi	10 (0.27%)
Indian	12 (0.33%)
Pakistani	119 (3.29%)
Black African	726 (20.08%)
Black Caribbean	442 (12.22%)
Mixed/ Multi-ethnicity/ Dual Heritage	636 (17.59%)
Black/ Black other	108 (2.98)
Black British	49 (1.35%)
South East Asian	20 (0.55%)
Latin American	8 (0.22%)
Middle Eastern/ Arab	17 (0.47%)
Other Ethnicity	126 (3.48%)
White Irish/ Irish Traveller	19 (0.52%)
White European/White Other	83 (2.29%)
Other	34 (0.94%)
Unknown	226 (6.25%)
Total	3,615

Table 3: Ethnicity of women and girls

As shown below when the Asian, Black and Other Ethnicity/Other categories are combined. Black is the highest (54.24%), with Asian being the second largest group of women and girls (30.45%).

In terms of age, Table 4 provides an age breakdown of the 1,541 BME cases reported by the 22 organisations. Whilst those aged 25-34 years comprised the largest age group, those aged 18-24 years and 35-44 years were also significant. This mirrors the age distribution of all sexual violence cases reported by responding organisations.

Age (years)	Under 16	16-17	18-24	25-34	35-44	45-54	55-64	65+
BME cases	8	93	309	503	352	188	74	14

Table 4: Age breakdown of BME women and girls

Sources of referral

BME women and girls were more likely to access independent specialist sexual violence organisations, especially those with specific BME support services, than SARCs.

Table 5 gives an overview of the main referral sources for sexual violence cases. It can be seen that self-referral constituted the highest source of referral (31.47%), followed by the police (21.89%).

Source of Referral	No. of cases	Range of overall referrals(%)	Total reported cases (n=17,449)(%)
Self-referral	5,492	7.4% - 70%	31.47%
Family/friends	472	12% - 6%	2.70%
GP	641	70% - 12%	3.67%
Police	3,820	40% - 80%	21.89%
Children's centre	108	20% - 4.8%	0.61%
Social services	258	12% - 80%	1.47%
Domestic violence services	448	70% - 57%	2.56%
A&E	8	20% - .40%	0.04%
School/college	219	20% - 12%	1.25%
Work colleague	271	55% - .88%	1.55%
SARCs	1,242	19% - 37%	7.11%
ISVAs	118	20% - 20%	0.67%

Table 5: Source of referrals

Referral sources for BME cases

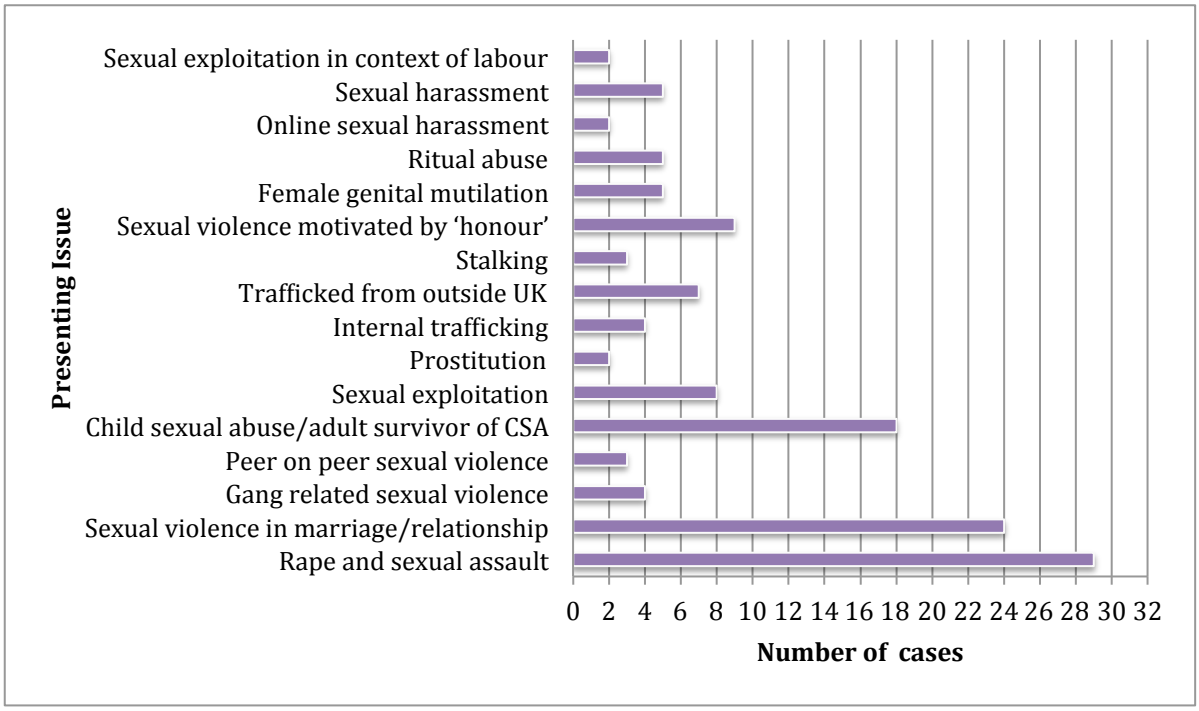
With regard to the main source of referrals for BME cases, the 30 organisations that provided this information reported that self-referral (n=15), the police (n=13) and domestic violence services (n=8) were the top three referral sources.

Source of Referral	No. of organisations
Self-referral	15
Police	13
Domestic violence service/refuge	8
Social services	5
SARCs	4
GP	2
Mental health	2
IAPT	2
School/college	1
Housing	1

Table 6: Source of referrals for BME cases

Presenting needs for BME women and girls

Rape and sexual assault, sexual violence in marriage/relationship and child sexual abuse/adult survivor of CSA were the top three presenting issues for BME women and girls.



Graph 5: Presenting needs for BME women and girls

Organisations also reported other issues that arose in their casework with BME women. These included:

- Sexual exploitation of women with insecure immigration status
- Sexual abuse within a familial context
- Sexual abuse of women accused of spirit possession
- Sexual exploitation of women with learning disabilities
- On-line grooming through dating websites
- No recourse to public funds
- Fear of accessing support and withdrawal of cases if gang related
- Lack of language support from agencies
- Increasing number of South Asian women disclosing CSA

Responses to BME women and girls

Organisations were asked to indicate the extent to which they can meet the needs of BME women and girls, and as the following table shows, of those that responded (n=37), almost two thirds (65%) said they can partly meet BME women's needs. Over a quarter (27%) said they can fully meet these needs whilst 8.1% said they found it difficult to meet BME women's needs.

Of the eight independent specialist sexual violence organisations with specific BME support services, three said they could fully meet needs, four said they could partly meet needs and one said it was difficult to meet needs. It is possible that these organisations under-estimated (or had a higher bar for assessing) their ability to meet BME women's needs than those without specific BME sexual violence services. Only one of the BME specialist domestic violence services said they could fully meet needs; for these organisations set up to respond to domestic violence the lack of experience of dealing with sexual violence cases reduced their perceived ability to respond to the needs of BME women. Thus, those with an expertise

in BME issues require greater input on issues of sexual violence whilst those with an expertise in sexual violence need to develop their knowledge and response to BME issues. All of the SARCs said they were able to partly or fully meet the needs of BME women and girls, though only three had developed any special measures to do this.

Description of Organisation	Fully meet BME needs	Partly meet BME Needs	Difficult to meet BME needs	Developed any measures
Independent specialist sexual violence member of RCEW (n=19)	4	12	3	19
Independent specialist sexual violence not member of RCEW (n=2)	1	1		1
SARC (n=7)	2	5		3
Domestic violence service (n=9)	2	5	1	5
National charities (n=1)		1		1

Table 7: Responses to BME women and girls

To gain more detail, respondents were asked if they had developed *any measures* to improve the support provided to BME women and girls. Over three-quarters (76%; n=28) had developed measures to enhance the support provided to BME women and girls. Notably, while all independent specialist sexual violence services said they had developed measures to improve support to BME service users, less than half of SARCs had done so. 28 organisations provided further information about the measures they had developed. It was evident that those with BME specific services and those located in areas with high BME populations had thought about their responses to diverse needs. At a basic level, organisations translated leaflets, provided some interpreting, organised some staff training and developed some links with BME groups. Measures developed by organisations, which can be considered as basic good practice, included the following:

- Specialist BME outreach service or a specialist BME outreach worker
- Recruitment of staff (paid and volunteers) from BME groups and with language skills
- Ongoing equality and cultural training and development within the organisation – multi-cultural competency
- Equality working group
- Links with specialist organisations and local BME groups
- Community awareness and engagement with BME groups, especially newly arrived migrant groups
- Specialist drop-in sessions targeted at particular BME groups
- Access to interpreting and translation of leaflets and information
- Research to explore issues for specific BME women and girls
- Training on BME women and sexual violence to other agencies/professionals
- Support for women with no recourse to public funds

Some organisations already had many of the above in place whilst others were in the process of increasing the diversity of staff/volunteers and their links with BME groups/organisations. Some worked in partnership with existing groups to support women from different communities. For others, addressing BME issues was described as a *'work in progress'* and a minority recognised they were not doing this *'well enough'*. Some simply responded to BME groups by stating that they welcome applicants from diverse communities when recruiting staff.

> We are committed to anti-discriminatory practice and work hard to ensure our services are meeting the needs of all the women who need them. The majority of our service users are from BAMER groups and this organisational

> expertise and commitment to accessibility is filtered down to the Rape Crisis service. All of our team have regular E&D training and we discuss issues related to equality & diversity at every supervision and team meeting. We also have specific targets on our work plans about casework identifying needs around protected characteristics and ensuring these needs are met. (RC)
>
> As an ethnically white UK worker I would like to believe I treat all clients equally regardless of gender, ethnicity, religious practice, sexual orientation, age etc. I wouldn't be doing my job right if I didn't do this. However, if someone were to say to me "look, because you are not BME you are just not getting this", while I would be appalled, I would also be open to hearing it and would address my own lack of learning in that area. I am very well trained I believe on equalities (and also just made that way), but I cannot pretend that I know BME experience as a non BME person. My expertise in working with BME women therefore is through my expertise in being a human and being aware that we all have diverse and sometimes complex needs. (SARC)
>
> Due to the small number of BME clients we do not have extensive experience in this area so it is important we are aware of what projects and specialist support is available locally and nationally to fully support women. (RC)

Sexual violence services with specific BME services (n=8) had developed various initiatives and much expertise, though some said they were still learning. It was evident there was some promising practice from which others in the sector could gain insight.

BME specialist organisations had several years' experience of providing support on domestic violence and some wanted to further build their expertise on sexual violence, and to address the needs of newly arrived migrant groups.

When asked what had particularly worked in improving the access of and support to BME women and girls, organisations mentioned the following:

- Having specialist BME services and staff
- Good multi-agency relations that generate referrals to BME women's groups.
- Outreach service located in local BME refuge and BME support agency
- Development and outreach work by BME staff in communities to build awareness, knowledge and trust (work that is increasingly not funded)
- Training on BME issues
- Staff, volunteers and trustees from BME groups
- Having strong links with local BME organisations and working within the community through existing groups in perceived 'safe' locations
- Keeping up to date with issues that impact on BME women and girls.
- Awareness work with BME women about sexual violence and giving them information about sexual violence services

Those that had addressed the needs of some BME groups were in the process of developing work with newer BME communities in which women were especially reluctant to disclose sexual violence. Some BME domestic violence services mentioned that they wanted to further develop their work on sexual violence.

Over two-thirds of all respondents (68.6%) reported that they collaborate or liaise with other organisations/groups regarding BME cases. While some gave concrete examples of this, for others this constituted little more than the intention to develop links with local BME groups. Interestingly, four of the seven SARCs said they did not liaise with other organisations in relation to BME cases.

Organisational confidence

Respondents were asked on a scale of 1 to 5 (where 1 represented very little and 5 a great deal) to report the level of their organisation's confidence in supporting BME women and girls. As can be seen from Table 8 respondents rated themselves at the mid-point and above (29.7%, 32.4% and 24.3% respectively). This could suggest that responding organisations completed the survey because they had already engaged with the issue of BME women's needs. Notably, 13.5% of organisations reported little or very little confidence in supporting BME women and girls.

Despite many not having developed any special measures or liaising with other organisations regarding BME cases, proportionally, SARCs claimed a higher level of confidence at level three and four than other organisations. BME domestic violence services highlighted the need to build their knowledge and collaboration on sexual violence. This is an important aspect of future developments as many of the BME women reporting sexual violence are disclosing sexual violence in a marriage/relationship.

Type of Organisation	Rating 1	Rating 2	Rating 3	Rating 4	Rating 5
Independent specialist sexual violence Service: RCEW member (n=19)	2	1	5	6	5
Independent specialist sexual violence Service: not member of RCEW (n=2)	-	-	1	1	-
Sexual assault referral centre (n=7)	-	-	3	3	1
Domestic violence service (n=9)	-	2	2	3	2
National charity (n=1)	-	-	-	1	-

Table 7: Organisational confidence in meeting BME needs

Barriers for BME women and girls

The following perceived barriers to BME women and girls accessing sexual violence support services were given by the 35 organisations that responded to this question:

- Lack of knowledge and awareness about support services and how to access them.
- Lack of specialist BME women's services.
- Fear of not being believed, understood or taken seriously; previous negative experiences of accessing support.
- Lack of awareness and sensitivity by services.
- Language barriers.
- *Cultural* factors (family, community) which prevent women from accessing support services by creating fear of disclosing and speaking out and of reprisals - stigmatisation and alienation from their communities and "family shame".
- Concerns about confidentiality.
- Isolation and accessibility.
- Denial by some communities and services.
- Perception of services as white with white staff
- Immigration status.

It was evident that many organisations perceived barriers to be only 'internal' to women and their communities, thus potentially placing responsibility for these barriers on BME women and communities, while only some also acknowledged 'external' barriers of racism, inaccessible services, and lack of knowledge among services and staff.

> The barriers experienced by BME women can be quite complex which require a proactive approach whereby services need to go out into the

> community and make women aware of such services through building trust and word of mouth. (DV/VAWG)
>
> Multitude of barriers although many of these cut across all survivors of SV including White British survivors. This could be the reception that women may think they will get (i.e. judgement that because of their particular background it will be assumed they experienced a particular type of abuse), an experience of discrimination in accessing a service in the past, feelings of shame resulting from the stigma, not being able to speak English or being literate to understand how to access the service, not thinking that the service is for them, thinking the service will not understand their particular life experience, struggling with immigration or no recourse to public funds issues… confidence in help-seeking behaviours. (RC)
>
> Lack of knowledge about what constitutes sexual violence and this is compounded by the media and rape myths. The issues relating to sex are taboo subjects so anything relating to sexual violence is even further removed from discussion. (BME DV)
>
> Racism and discrimination, stereotyping of young women from certain communities, some communities regard sexual violence as the ultimate taboo and confuse sexual violence with sexual desire and therefore offer women and girls little meaningful support from families, communities and religious organisations. (RC)

Organisational barriers

> We've worked over the last few years to ensure that our support services are as good as they can be in the support they provide to BME women. This is of course a continual process as we learn more all the time. The next step would be to offer specialist BME women only services as there are no specialist BME VAWG services in our county at the moment. (RC)
>
> We respond to referrals into the service but do not do promotional work to engage with BME Groups. (RC)

A range of barriers in supporting BME women and girls within organisations were highlighted.

- 'Cultural' differences generally were cited by many as a barrier to supporting BME women and girls though little information was provided about this.
- Lack of training to staff on BME issues was mentioned by many as the key reason for not being able to address BME issues, though this was often in relation to 'cultural' issues rather than those of access and equality.
- Disclosure from BME women was reported to be slower as trust building between women and support workers took longer.
- BME specialist domestic violence services lacked the resources to build their capacity to offer support for sexual violence but are often viewed to be best placed to respond to BME women by other local mainstream services.
- Although many attempted to provide language support, language remained a barrier for many in responding effectively to the needs of BME women and girls. In a context where resources were generally scarce, this was seen to further impact on language support.
- A lack of expertise as a result of limited staff and volunteers with community languages within their organisations was cited by many mainstream services.
- It was reported to be difficult to reach individual women in areas with few BME groups.

Views about existing services

> In general services to women experiencing sexual violence are scarce. For BME women there are even more so. (RC)

> We need to think in terms of what more we need to learn and understand about supporting BME communities. (DV/VAWG)

Services for BME women experiencing sexual violence were seen to be extremely limited, with responses such as *'there is a real shortage of specialist BME services', 'specific sexual violence specialist provision is scarce'*, *'insufficient'* being common. Despite a VAWG agenda, most provision was considered to still focus on domestic violence. The engagement of BME women with mainstream services was a concern for many and services were viewed as generally inaccessible. Some generic services believed that BME women could access all existing services, betraying an insight into the complex issues that prevent women from disclosing sexual violence and accessing support. Others strived to offer survivors *'support they need and deserve'* but recognised that specialist services were required for BME women locally and nationally but were currently not well developed.

> There is plenty of evidence showing the need for specialist BME women only services which are not currently available in our area, so this is something we would like to be able to offer, or alternatively if there was a new and emerging service we would be keen to work with them if they wanted us to and ensure we could work collaboratively rather than competitively at all levels. (RC)

> All services are available to them as they are to everyone else. They are free to access the ones they feel most comfortable with, without pressure. (SARC)

> It should not be a regular service with an 'add on', it needs to be a specialist service. (BME DV)

It was evident that the availability of services for BME women was uneven, with none reported in many areas. The range of sexual violence in BME women's lives was thought to be hidden and only responded to by those that had thought about their needs, including BME specialist domestic violence services, which had limited training and expertise in responding to sexual violence. It was thought that not all services were aware of the needs of BME women and girls and this was exacerbated by a lack of interpreters for those whose first language is not English.

Where good services existed, especially in London, the funding climate was considered to create insecurity and lead to closure of services. Moreover, smaller services often only targeted a specific community. Others had little idea of what services existed and suggested a directory was needed. Capacity building, through training and specialist staff and increased financial resources, were seen to be required to *'support small organisations such as RCO's to deliver crucial services'.*

Aside from greater resourcing, respondents thought that to address the current lack of cohesion, better partnership among existing organisations was needed to successfully support BME women and girls through, for instance, establishing better referral pathways.

In addition to support for survivors, there was a strong view that specialist knowledge among key stakeholders was lacking. It was suggested that awareness work and training was needed on BME issues among statutory services to ensure all survivors receive a professional service.

Processes/measures for feedback

Not all responding services had measures in place for service user feedback. Feedback forms and exit forms were minimum measures reported to be in place though a number also implemented before and after questionnaires and comment forms during engagement and reported making changes based on feedback received. Independent specialist sexual violence services in particular put survivor voices and experiences at the centre of their services and many had developed extensive measures to enable this to happen.

However, only some respondents had specifically obtained feedback from BME service users (n=13); below are some of the comments made about this by BME women accessing services:

> Having a support worker who spoke French was better than having an interpreter, I felt the support worker understood much more, and it was easier to talk to her.

> I cannot tell you how much safer I was having someone who understood my background. It really helped me.

> I was scared at first that people in my community would find out, and this would make life difficult for me. I really understood how people could help me and that things could be kept private. Where things were different between us, we talked about it.

> My grandfather abused me for years, you are the first person I have been able to share it with, since our conversation I have been able to share it with a few more family members as it gave me the courage to say I have a right to talk about this.

Findings from interviews

A number of issues about responses to BME women and girls by sexual violence services were identified in the interviews with key experts, which are detailed in this section.

Gaps in current service responses

As identified in the organisational responses to the survey, many of the interviewees spoke about gaps in current service provision and highlighted the need for greater development in responses to BME survivors of sexual violence.

In/equality of access

Whilst there was acknowledgement of the need to better understand and profile current models of work within the sexual violence sector, nearly all of the interviewees felt that much more work needed to be done by individual services to address barriers and to ensure equality of access. That some independent specialist sexual violence services had developed work with BME women and girls which could be replicated across the country was also noted. However, promising practice was seen to be limited by interviewees and the experiences and support needs of BME survivors were considered to be largely overlooked by the majority of service providers –'*the needs of BME women continue to be invisible'.*

The importance of agencies reviewing their data in terms of equality to address current service gaps and barriers was especially emphasised.

> More reflective provision, for example, Brent's BME population is 33 per cent and 18 per cent of women experience sexual violence. We need proportional services for women, using demographics to understand and having services to reflect that.

> There are no specific advocacy (ISVA) services that are BME specific for BME women. We need ISVAs who are trained to work with BME women with languages.

Nearly half of the interviewees also raised concerns about BME women's engagement with Sexual Assault Referral Centres (SARCS). These interviewees question the existing knowledge base within SARCs about the context within which BME women and girls experience sexual violence, whether these services are routinely accessed by BME women and girls and a concern about gender neutral approaches, which could impact on women's (including BME women and girls) engagement with SARCs. For instance, an insufficient awareness of how equality is embedded within service delivery was commented upon. Concern was also expressed about a lack of understanding about the impact of sexual violence, which can then lead to inconsistent and poor practice by some professionals:

> There are a lot of unskilled staff with no understanding of BME issues.
> A system with a vast amount of resources. For example, we know of situations where during forensic examinations women are asked to position themselves on all fours!

Contesting homogenous approaches/beyond language and immigration

Concern about the lack of interrogation within individual organisations across the sexual violence sector about the range of barriers that exist for BME women and girls was raised by interviewees and seen to lead to limited responses. For instance, viewing BME women's experiences as uniform rather than diverse and nuanced, or as solely linked to issues of language, poverty or immigration, was viewed as limited and a perspective that could potentially fuel stereotypical assumptions about need/vulnerability and result in discriminatory practice. This, in turn, can prevent BME women's access to and 'visibility' within existing services. The need for a more sophisticated and fluid understanding of BME women's experiences and for organisations to scrutinise their assumptions and practice was emphasised:

> We have a one-size-fits all approach to services. The understanding of BME women has broadly been collapsed. BME women are also middle class, professionals, so what does this mean for sexual violence? The conversation needs to be moved on beyond poverty, immigration. How do we keep the issue of language, how to have a service that is inclusive for all? How do we work with lesbians and transgender? This is a gap…not thought about nuances of the fourth/ fifth generation which needs affirmation, a service for dual heritage women…

Gaps in support for young BME women

The gap in age-appropriate support services for young BME women was also identified. For example, the need for more integrated rather than issue-specific responses was noted as a barrier to addressing the support needs of young women.

> We know that when young women experience sexual violence perpetrated by their peers there is a large amount of confusion as to what this is called - sexual bullying, domestic violence, child sexual exploitation, serious youth violence, harmful sexual behaviour etc. We still need to work out how to move from a siloed approach to one which addresses the needs of young people affected by violence/abuse.

Funding/ capacity

A number of the interviewed organisations had identified gaps in support to BME women and girls and made efforts to develop specific initiatives to address this. For some, this involved attempts to establish independent BME women-only services, whilst others had sought to improve collaboration with local BME women's organisations. However, the majority spoke about the lack of locally available services, gaps in funding, and capacity issues as hampering opportunities for service development, whether this was for ensuring the availability of interpreters, developing dedicated BME only spaces and/or accessing resources to improve opportunities for partnership work. The 'austerity' cuts to equalities-based projects were also identified as a significant challenge for existing service providers.

> There are some groups of BME women that are under-represented from the data. There isn't always the capacity to do the necessary outreach. I'm not saying that it never happens but if they are going through a phase where they don't have the capacity because they have a hundred women on the waiting list, they won't proactively go out and look for new women as they don't need to.

> We can fully meet their needs but it's difficult so we do have to access other services. For example, we don't have the capacity for immigration/asylum cases, there is a lack of budget for interpreters, supporting deaf women.

Responses from statutory agencies

All of the interviewees raised concerns about the practice and attitudes of some statutory agencies, which were considered to be inconsistent, poor and discriminatory. Nearly all spoke about problematic responses in relation to women's interaction with frontline workers within agencies, such as the police, health, and social services. There was a significant concern that poor responses were still too often driven by harmful personal beliefs and assumptions which led to victim blaming rather than victim protection.

> Not a good response from the police, for example a woman assaulted by her father-in-law, the police saw him and then told her 'I'm getting a different story' and ended up blaming her… Women don't want to disclose to the police and they won't go to Social Services.

> GPs - do not ask correct questions, do not see women on their own.

Young women and those with immigration/asylum issues were considered to be more likely to encounter victim blaming attitudes. The tendency for some agencies to continue to categorise survivors within a binary of innocent or blameworthy, for example, was viewed as a problem, which resulted in a 'hierarchy of victims', increasing the likelihood of restrictive and sometimes discriminatory responses. The following interviewee identified attitudes that normalise sexual violence towards young women who are gang-associated:

> We have a constant concern with the police and the relationship with the police. We have an advocacy service and our experience is that there is blatant discrimination against women, in particular, young women. The police see women as 'good', 'not so good' and 'bad' victims, e.g. young women with gang affiliation and association and the normalisation of sexual violence as part of the lifestyle.

Similarly, problems that occur when agencies operate within specific assumptions about what a victim-survivor should look like were emphasised, as well as the impact of this on women's visibility and access to support:

> Audit processes have identified a continued blindness to the experiences of some BME young women with the assumption that those who are sexually exploited, for example, are White British young women. BME young women are often found in youth justice services or pupil referral units where they are being worked with as an offender rather than in an attempt to recognise their experiences of victimisation.

Similarly, when agencies begin from a starting point of blame rather than belief, this was seen to impact on how young women engaged with statutory services in the future:

> A huge barrier for young women is 'believability'. We have found that where cases have been very severe or there are historical situations of sexual abuse, there are lower levels of belief by social services and other professionals. This is a huge factor. It then silences women who will then withdraw from support services and they eventually fall under our radar.

Furthermore, responses to women who are not British nationals were seen to be particularly poor. Such women were reluctant to approach the police because of a fear that it would result in criminalisation rather than protection – *'women are scared to go to the police in case they are put into detention when the police find out'.* Women's fears about negative responses from statutory agencies were often reflected in how some were treated in practice. This was reiterated throughout the interviews:

> The police have told women who have children and who only have a visa that she can leave the country but she will have to leave the children with her husband.

That engagement with the CJS was sometimes contradictory with harmful repercussions for women also noted. For example, where women decided not to pursue a prosecution this sometimes led to a prosecution being initiated against them.

Policy gaps

The *universal* VAWG approach adopted by policy makers, funders and commissioners was one of the greatest challenges identified in addressing the gaps in sexual violence provision. This was viewed as a major factor contributing to the failure of policy makers in recognising and addressing the support needs of BME women and girls within VAWG related strategies. This approach was also seen to prevent frontline providers from designing and developing interventions that have the greatest benefit for BME survivors.

> A barrier is VAWG funding, funders pushing certain agendas, certain packages, universality, all this marginalises BME women.

> BME women are no longer anybody's priority, maybe they never were, maybe it was all rhetoric.

Linked to this issue, a number of interviewees commented on the lack of understanding about the range, nature and impact of sexual violence. Nearly all felt that commissioners were less aware of the range of VAWG, including sexual violence, and its particular implications for BME survivors, resulting in the under-development of policy and practice on sexual violence.

> We haven't come across any commissioners that understand issues affecting BME women. We have brought in leadership courses but the local authority only thinks about BME issues as 'celebration events', festivals and it's only ever linked to Black History Month.

In addition to highlighting the gaps in general understanding about sexual violence, interviewees spoke about the lack of understanding about the risks and vulnerabilities that are likely to be present in BME women and girls' lives, such as multiple perpetrators or the vulnerability to sexual violence by survivors of forced marriage.The lack of consideration of corrective rape within immigration/asylum decision-making processes was also identified:

> I want to expand the sense of sexual violence, to include 'corrective rape', which is not considered sexual violence in immigration cases. It is not considered a viable cause for not returning women to her original country.

For some, this lack of understanding stemmed from an excessive focus on 'culture' and the cultural framing of sexual violence, which views it as 'normal' within BME communities.

> BME women and sexual violence is not being thought about locally. And there is a narrow definition of what that might be. There is a lack of understanding about rape for instance – assumption that it's ok 'in that culture'. There is also a taboo around issues like childhood sexual abuse.

This framing of sexual violence as a 'cultural' problem was considered problematic as it resulted in an over-reliance on non-gendered approaches to addressing the issue, particularly where there was a lack of dialogue with women's organisations.

> Locally, there is a fixation with looking at community specific responses which, for example, legitimatise sharia courts or sharia laws or localised community councils. This feeds into racist and sexist ideologies and

> ultimately fragmented and inappropriate service responses. It reinforces 'otherness' where it is assumed that this is what these people do anyway.

Other factors identified as a barrier to the development of informed policy and practice included a failure to conduct rigorous equality impact assessments of current services to identify and address any barriers to access. The tendency for policy makers to focus on criminal justice reform, at the expense of more holistic solutions to sexual violence, was also noted.

> If the Coalition Government continue in the way they are, BME women will lose out. They don't report sexual violence to the same degree. Responses won't improve as all the money goes into the CJS response. We need to think beyond the CJS.

> We have worked with the Home Office on 'full-time' dedicated roles. These have never been evaluated. ISVA data would be really useful here.

Promising approaches

Existing models of work, with BME survivors, albeit limited, were shared by a number of the interviewees. Those who had developed such responses found that this improved levels of disclosure and access to their services by BME women and girls.

> The dedicated work led to a 24% increase in disclosures and access to our service in the first year, 72% for the helpline. Whilst we have seen an improvement in BME women accessing the specialist outreach service we know that the barriers and obstacles for BME women are significant and that's why we conducted the research to develop this work further.

However, there was a strong consensus that there was a need to further develop work to address issues of access across the sector.

Whilst BME-led VAWG services are more commonly associated with support on domestic violence or forced marriage, there is less knowledge about the role they play in delivering support to survivors of sexual violence. Interviewees identified some BME-led generic women's services that had initiated projects on sexual violence. These include: independent specialist sexual violence services that have developed approaches/models of work with BME women and girls that recognise their intersectional location and discrimination; an initiative to address the specific support needs of young women, including BME young women; an early intervention/prevention project with young women; and specialist sexual violence services that have improved engagement with local BME community organisations through partnership work.

Some interviews were conducted with generic community-based organisations that provide generic services through places of trust and support, such as welfare, advice and advocacy services for both men and women, often for those experiencing different forms of marginalisation and exclusion. It was evident that such organisations are routinely accessed by large numbers of women from diverse communities, a number of whom have disclosed sexual violence, along with other forms of VAWG. Although these community organisations are not funded to provide such support services and are entirely reliant on volunteers, workers are often called on by statutory services for unpaid translation and engagement with BME women and girls. Consequently, they believed their expertise was rarely acknowledged and that working relationships remained unequal. Volunteers tend to provide women with welfare/rights-based advice and referral to other services, including domestic violence and rape crisis services. Awareness raising sessions take place to initiate discussion on issues such as mental health and domestic violence and frequently result in disclosure.

> Attending classes encourages women to talk and to seek help. We can give information to women so they know where to go and what to do. We talk about domestic violence, sexual violence, children, benefits. The women's partners do not check and the partners are not there…Women will not ask

> questions during the day but will start talking afterwards. They will contact me individually.

Such community-based organisations emphasised the importance of developing a response to sexual violence because of specific barriers that prevent BME women and girls from disclosing.

> I want to set up a group that helps women rape victims – through family members, husbands, trafficking, war situation - in this country. It is then possible to break the taboo that it is not their fault, if women can talk to other women. We have to pass on the message to women that we understand, a lot of people understand, don't keep it inside.

Women-centred approach

Whilst there was strong support for improving opportunities for partnerships with non-VAWG community based organisations, a number also highlighted obstacles to developing this work. For instance, resistance had been encountered by some from organisations and/or 'community' representatives who lacked a gendered perspective:

> We started setting up a satellite service but there was resistance from the community, including GPs, the Imam, community services and organisations. They did not want the service. We knew there were issues such as street-based prostitution and rape coming up when we spoke to women.

These partnerships were seen to be most effective with organisations that have a strong women-centred perspective:

> We can't work with women's groups that won't challenge the system. Without a feminist base we don't challenge the values – we can't work with these types of community groups.

Improving responses to BME women and girls

A range of suggestions were made about how to improve current responses.

Collaboration between policy makers and VAWG experts

Greater collaboration by policy makers with VAWG, and especially BME VAWG, experts in the design of commissioning and tendering processes was a key area highlighted.

Strengthening capacity of sexual violence and BME-led women's services

The need for policy-makers to further invest in the sustainability of local services within the sexual violence and BME-led sector was emphasised. These sectors have an established track record of work with BME women and girls and the requisite quality assurance measures that reflect the development of effective approaches to supporting BME women and girls.

> We need to better utilise existing spaces (BME) that already have an established case-management approach and build organisational capacity in responding to sexual violence. So it's not always about creating new spaces but enabling more dialogue between generic (sexual violence) and specialist BME sector providers.

The majority of interviewees identified the need for closer partnership work between sexual violence and BME women's organisations that primarily focus on domestic violence as well as increasing joint work with non-VAWG community based grassroots organisations. This was viewed as a significant way of improving access to support services.

Choice

The majority of interviewees felt that a choice of service was paramount in supporting BME women and girls. *Choice* was not defined as a mainstream versus specialist BME service response. Instead, interviewees identified the importance of ensuring that existing rape crisis provision is both *accessible* and *accessed* by different groups. Alongside improvements in mainstream responses, the need to improve partnership work and further strengthen BME women-led services was emphasised.

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

Similarly, there was some caution against an either/or position as most interviewees felt strongly that a reliance on improving mainstream services alone would not improve BME women's access and disclosure to sexual violence services.

> I would worry about simply relying on mainstream sexual violence services to meet the needs of BME women. Some will do it and some won't. I would prefer women to have choices.

Training

The value of ongoing training for frontline professionals on sexual violence was identified as a particular need by all of the interviewees. Training was seen to be needed to raise the awareness of statutory professionals across the board. It was also identified for mainstream and BME-led domestic violence services as well as for mainstream sexual violence services. The value of training programmes that addressed sexual violence in the context of other forms of VAWG, such as female genital mutilation, was highlighted:

> I don't think any of the (rape crisis) centres have any particular expertise on issues such as female genital mutilation or women experiencing forced marriage who also experience sexual violence. I'm sure it would be addressed in their counselling, and services would have a broad VAWG perspective, but we don't know for sure especially if they are experiencing multiple forms of VAWG.

Community-based outreach

The need for policymakers to support the development of specialist women-centred, holistic and diverse interventions, particularly those developed by agencies with a history of delivering women and BME women-only support services was emphasised. Nearly all highlighted the importance of increasing community-based outreach and awareness work on sexual violence to address the numerous barriers that women and girls experience.

> The sense of self is less and family more. It is difficult to talk to a woman as herself because her family is in the room when she is in the room. Women cannot afford to be away from their family. Women feel they have to stay with their partner, as well as the community. There are poly-perpetrators in the home. BME women are more reticent in talking about stranger rape and are less likely to come forward for help. There is stigma and shame. Women also experience racism. In relation to services, a woman is apprehensive about how services would understand her experiences, and how she is viewed by her community is key.

Greater resourcing was also thought to be required to enable the development of 'community-based' and 'located' initiatives to address the need for specific work with women and men in some BME groups.

> If we mobilise men, then women can access services. We need a new way of thinking, a lively conversation. We need young people as champions/ ambassadors within communities.

> Some men have no involvement with family life because of the war; they went to prison, were tortured. We have to work with both men and women.

Given a historical lack of dialogue and work on sexual violence at a grassroots level across a number of diverse communities, this was considered a crucial step, along with the development of specific services:

> In terms of sexual violence, women don't know how to talk about this. Girls don't want to disclose to other people even if they talk to us… We need to start in small steps.

Setting standards

Further development of models of promising practice and standards which guide and support organisations across the sexual violence sector to develop informed and consistent support for BME survivors was regarded as crucial. Interviewees emphasised the need to acknowledge women-led and BME women-led spaces as part of the minimum standards. The need for national second-tier organisations to support local sexual violence services to develop more robust policy and practice in the recruitment of BME staff in senior and frontline positions was also viewed as critical to supporting organisations to become more responsive to diversity.

Improving statutory service responses

There was a strong consensus about the importance of improving the overall responses of statutory agencies. It was thought that the value of investing in a broader approach to therapeutic provision, to address the health impact of sexual violence, should be recognised by health commissioners as well as embedding appropriate support for survivors within the criminal justice system.

> We need different kinds of clinical models. It is not good for women to just sit and talk. Other types of therapies, such as cooking, gardening, how to dismantle a car engine are needed.
> We need a specialist CJS approach - sexual violence courts, specialist judges, prosecutors.

Young women

The need for policy-makers and frontline professionals within the statutory and voluntary women's sector to strengthen partnerships to develop more nuanced responses that address the contexts within which young women experience sexual violence, but which also offer direct practical and emotional support, was emphasised by many of the interviewees.

> Services need to operate within partnerships that are able to change the social contexts in which sexual violence occurs. Without contextual changes service interventions with individual young women can result in an escalation of risk and a need to relocate them for their own physical safety. If a rape has occurred within a peer group, school, or other social site where young people spend their time the cultural context that facilitated that sexual violence will remain without a concerted intervention from the most appropriate partners.

Greater collaboration between the women's sector and children's services was also viewed as critical in supporting young women.

> The women's sector rarely works in partnership with the children's sector limiting opportunities to develop both gender and age appropriate interventions for young women. A number of services rely on referrals for young women from statutory agencies and therefore only work with groups who are already visible to social workers.

Conclusions and Recommendations

Key Conclusions

As the first study of its kind, this research was carried out to address the lack of knowledge about responses to BME women and girls' experiences of sexual violence. Overall, the research identifies a number of gaps and promising practice which provide opportunities for improving pathways to care and support.

There is a lack of understanding and knowledge about sexual violence and its specific impact on BME women and girls among commissioners, policy makers and practitioners. Commissioners were less aware of different ways in which VAWG, including sexual violence, has particular implications for BME survivors, resulting in an underdevelopment of policy and practice on sexual violence. This is combined with a lack of funding and resources for the development and sustenance of dedicated and holistic BME services.

Additional issues that arose included: inconsistent monitoring of ethnicity, along with other equality strands; a need for more partnership work with those organisations with an expertise on BME women and girls; gaps in training and organisational development to support specialist sexual violence and BME domestic violence/VAWG services to develop their knowledge and practice.

More worrying, however are the ways in which BME women and girls' experiences and needs can be mis/understood, which is indicative of an approach that reinforces commonly held assumptions about BME communities. The findings underline the need for further work in this area. However, the study also identifies promising practice, primarily among independent specialist sexual violence services and specialist BME VAWG/domestic violence services, an important starting point for building future developments to improve services responses to BME women and girls. During the next phase of this work, we plan to further develop models of promising practice as a tool for organisations to develop their practice further.

These key findings have been taken into consideration when making the following key recommendations.

SPECIALIST

Identify and assess potenial gaps and barriers for BME women and girls accessing their services.

GRASSROOTS

Strengthening engagement and partnership work with local grassroots organisations would help to improve BME women and girls access to specialist advice and support.

LOCAL

Improve understanding and awareness of the context within which BME women and girls experience sexual violence and face barriers to accessing support services.

KNOWLEDGE

Agencies with a responsibility for addressing sexual violence should be appropriately trained as part of on-going professional development.

NATIONAL

Capturing the whole range of women and girls experiences of sexual violence, as part of a continuum of violence across different equality strands.

➔ *BME women and girls experiences of sexual violence should be a mandatory consideration within existing cross-governmental department strategies and action plans which seek to respond to and improve pathways to long-term care and support following rape and other forms of sexual violence*

National partners: Department of Health, Ministers, Public Health England, NHS commissioning board, Ministry of Justice (MOJ); Home Office, DFEE, CPS, Police

- Acknowledge that many BME women and girls in the UK experience sexual violence, which is both similar and different to their non-BME counterparts. This requires capturing the whole range of women and girls experiences of sexual violence, as part of a continuum of violence across different equality strands, rather than individual and specific categories of violence which can lead to under-identification of sexual violence, siloed and fragmented service responses.

- Ensure that there is adequate guidance and investment (nationally and locally) to assist local areas to develop robust and integrated service responses to BME women and girls.

- Data should be disaggregated on the basis of gender, race and all protected equality characteristics to measure performance and influence service responses e.g. NHS public health outcomes data and indicators on sexual violence, CPS data on prosecutions.

➔ *Commissioners and policymakers should work with local partners to improve their understanding and awareness of the context within which BME women and girls experience sexual violence and face barriers to accessing support services.*

Local partners: specialist sexual violence and BME women's organisations, Clinical commissioning groups, health and wellbeing boards, PCCs, local Healthwatch, organisations with a specialism on working with particular equality groups e.g. young women, police and other CJS partners, schools and further education

- Identify and develop collaborative working relationships with sexual violence and BME VAWG specialist organisations.

- Work with local partners and experts on sexual violence/equalities issues to conduct a local needs assessment/audit of local service provision to identify policy and service gaps as part of producing a joint strategic needs assessment (JSNA).

- Use the information to inform local strategies to ensure that services are reflective and responsive to local need. This should and could include developing the capacity and sustainability of specialist sexual violence and BME VAWG organisations to develop appropriate service responses.

➔ *Mainstream sexual violence specialist organisations should identify and assess gaps and barriers for BME women and girls accessing their services.*

Specialist partners: Independent specialist sexual violence organisations, BME women's VAWG organisations, organisations with a specific approach to working with young women

- Develop and review robust systems of ethnic monitoring which simultaneously measure and monitor performance across all strands of equality.

- Undertake an annual equalities audit to capture data on take up of current services in order to inform strategic planning and practice.
- Develop active, meaningful partnership links with local BME VAWG organisations to develop expertise and identify sustainable opportunities for joint work on improving pathways to care and support.
- Greater collaboration and dialogue across different sectors, e.g. agencies working with children and young people, to identify opportunities for improving support to young women affected by sexual violence.

➔ *Agencies with a responsibility for addressing sexual violence should be appropriately trained as part of on-going professional development.*

Statutory and voluntary sector agencies

- Training should be developed which provides a nuanced understanding of BME women and girl's social location and issues that have an impact across the different equality strands in the context of sexual violence. This should be developed and delivered in partnership with local/national BME-led partners and experts.

- Training should be targeted at both statutory agencies and mainstream specialist sexual violence organisations. BME women's DV/VAWG organisations should ensure all staff are trained on sexual violence and about the specific issues that impact on new and emerging BME groups.

- RCEW should use the key messages of this research to inform all work with its members, including improving the consistency and quality of service responses to BME survivors and identifying existing promising practice by using and reviewing tools such as the Rape Crisis National Service Standards, to drive on-going improvements.

➔ *Strengthening engagement and partnership work with local grassroots organisations would help to improve BME women and girls access to specialist advice and support.*

- Developing the capacity of BME women-centred community-based organisations, with a feminist-intersectional analysis, to provide spaces for accessing specialist support is an avenue for doing this work.

- Models of work should be developed and delivered in partnership with BME VAWG and specialist sexual violence organisations and require investment and support from funders and commissioners.